MISSISSIPPI LEGISLATURE REGULAR SESSION 2005

By: Representative Bentz

To: Public Health and Human Services; Insurance

HOUSE BILL NO. 1374

1 AN ACT TO PROVIDE FOR THE REGULATION AND LICENSURE OF HEALTH
2 CARE SERVICE PLANS BY THE DEPARTMENT OF INSURANCE; TO PROVIDE FOR
3 THE PAYMENT OF MEDICAL PROVIDER CLAIMS BY A HEALTH CARE SERVICE
4 PLAN AND THE RESOLUTION OF CLAIMS DISPUTES; TO PROVIDE FOR
5 INTEREST TO ACCRUE IF AN UNCONTESTED MEDICAL PROVIDER CLAIM IS NOT
6 REIMBURSED BY THE PLAN WITHIN A PRESCRIBED TIME PERIOD; TO
7 PROHIBIT A HEALTH CARE SERVICE PLAN FROM ENGAGING IN AN UNFAIR
8 PAYMENT PATTERN IN ITS REIMBURSEMENT OF A MEDICAL PROVIDER; TO
9 AUTHORIZE THE COMMISSIONER OF INSURANCE TO IMPOSE SANCTIONS ON THE
10 PLAN FOR ENGAGING IN AN UNFAIR PAYMENT PATTERN; AND FOR RELATED
11 PURPOSES.

12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

13 **SECTION 1.** The Legislature finds and declares the following:

14 (a) Health care services must be available to citizens
15 without unnecessary administrative procedures, interruptions or
16 delays.

17 (b) The billing by providers and the handling of claims
18 by health care service plans are essential components of the
19 health care delivery process and can be made more effective and
20 efficient.

21 (c) The present system of claims submission by
22 providers and the processing and payment of those claims by health
23 care service plans are complex and are in need of reform in order
24 to facilitate the prompt and efficient submission, processing and
25 payment of claims. Providers and health care service plans both
26 recognize the problems in the current system and that there is an
27 urgent need to resolve these matters.

28 (d) To ensure that health care service plans and
29 providers do not engage in patterns of unacceptable practices, the
30 Department of Insurance should be authorized to assist in the

31 development of a new and more efficient system of claims
32 submission, processing, and payment.
33 **SECTION 2.** Each health care service plan and, if applicable,
34 each specialized health care service plan shall meet the following
35 requirements:
36 (a) All facilities located in this state including, but
37 not limited to, clinics, hospitals and skilled nursing facilities
38 to be utilized by the plan shall be licensed by the State Board of
39 Health, where licensure is required by law. Facilities not
40 located in this state shall conform to all licensing and other
41 requirements of the jurisdiction in which they are located.
42 (b) All personnel employed by or under contract to the
43 plan shall be licensed or certified by their respective board or
44 agency, where licensure or certification is required by law.
45 (c) All equipment required to be licensed or registered
46 by law shall be so licensed or registered and the operating
47 personnel for that equipment shall be licensed or certified as
48 required by law.
49 (d) The plan shall furnish services in a manner
50 providing continuity of care and ready referral of patients to
51 other providers at times as may be appropriate consistent with
52 good professional practice.
53 (e) (i) All services shall be readily available at
54 reasonable times to all enrollees. To the extent feasible, the
55 plan shall make all services readily accessible to all enrollees.
56 (ii) To the extent that telemedicine services are
57 appropriately provided through telemedicine, these services
58 shall be considered in determining compliance with this act.
59 (f) The plan shall employ and utilize allied health
60 manpower for the furnishing of services to the extent permitted by
61 law and consistent with good medical practice.
62 (g) The plan shall have the organizational and
63 administrative capacity to provide services to subscribers and

64 enrollees. The plan shall be able to demonstrate to the
65 department that medical decisions are rendered by qualified
66 medical providers, unhindered by fiscal and administrative
67 management.

68 (h) (i) All contracts with subscribers and enrollees,
69 including group contracts, and all contracts with providers, and
70 other persons furnishing services, equipment, or facilities to or
71 in connection with the plan, shall be fair, reasonable and
72 consistent with the objectives of this chapter. All contracts
73 with providers shall contain provisions requiring a fast, fair and
74 cost-effective dispute resolution mechanism under which providers
75 may submit disputes to the plan and requiring the plan to inform
76 its providers upon contracting with the plan, or upon change to
77 these provisions, of the procedures for processing and resolving
78 disputes, including the location and telephone number where
79 information regarding disputes may be submitted.

80 (ii) Each health care service plan shall ensure
81 that a dispute resolution mechanism is accessible to
82 noncontracting providers for the purpose of resolving billing and
83 claims disputes.

84 (iii) On and after January 1, 2006, each health
85 care service plan shall annually submit a report to the department
86 regarding its dispute resolution mechanism. The report shall
87 include information on the number of providers who utilized the
88 dispute resolution mechanism and a summary of the disposition of
89 those disputes.

90 (i) Each health care service plan contract shall
91 provide to subscribers and enrollees all of the basic health care
92 services, except that the Insurance Commissioner may, for good
93 cause, by rule or order exempt a plan contract or any class of
94 plan contracts from that requirement. The Insurance Commissioner
95 shall by rule define the scope of each basic health care service
96 which health care service plans shall be required to provide as a

97 minimum for licensure under this chapter. Nothing in this chapter
98 shall prohibit a health care service plan from charging
99 subscribers or enrollees a copayment or a deductible for a basic
100 health care service or from setting forth, by contract,
101 limitations on maximum coverage of basic health care services,
102 provided that the copayments, deductibles, or limitations are
103 reported to, and held unobjectionable by, the Insurance
104 Commissioner and set forth to the subscriber or enrollee.
105 Nothing in this section shall be construed to permit the
106 Insurance Commissioner to establish the rates charged subscribers
107 and enrollees for contractual health care services.
108 **SECTION 3.** A health care service plan, including a
109 specialized health care service plan, shall reimburse claims or
110 any portion of any claim, whether in state or out of state, as
111 soon as practical, but no later than thirty (30) working days
112 after receipt of the claim by the health care service plan, or, if
113 the health care service plan is a health maintenance organization,
114 forty-five (45) working days after receipt of the claim
115 by the health care service plan, unless the claim or portion
116 thereof is contested by the plan in which case the claimant shall
117 be notified, in writing, that the claim is contested or denied,
118 within thirty (30) working days after receipt of the claim by the
119 health care service plan, or if the health care service plan is a
120 health maintenance organization, forty-five (45) working days
121 after receipt of the claim by the health care service plan. The
122 notice that a claim is being contested shall identify the portion
123 of the claim that is contested and the specific reasons for
124 contesting the claim.
125 If an uncontested claim is not reimbursed by delivery to the
126 claimants' address of record within the respective thirty (30) or
127 forty-five (45) working days after receipt, interest shall accrue
128 at the rate of fifteen percent (15%) per annum beginning with the

129 first calendar day after the thirty (30) or forty-five (45)
130 working day period. A health care service plan shall
131 automatically include in its payment of the claim all interest
132 that has accrued pursuant to this section without requiring the
133 claimant to submit a request for the interest amount. Any plan
134 failing to comply with this requirement shall pay the claimant a
135 ten dollar ($10.00) fee.
136 For the purposes of this section, a claim, or portion
137 thereof, is reasonably contested where the plan has not received
138 the completed claim and all information necessary to determine
139 payer liability for the claim or has not been granted reasonable
140 access to information concerning provider services. Information
141 necessary to determine payer liability for the claim includes, but
142 is not limited to, reports of investigations concerning fraud and
143 misrepresentation, and necessary consents, releases and
144 assignments, a claim on appeal or other information necessary for
145 the plan to determine the medical necessity for the health care
146 services provided.
147 If a claim or portion thereof is contested on the basis that
148 the plan has not received all information necessary to determine
149 payer liability for the claim or portion thereof and notice has
150 been provided pursuant to this section, then the plan shall have
151 thirty (30) working days or, if the health care service plan is a
152 health maintenance organization, forty-five (45) working days
153 after receipt of this additional information to complete
154 reconsideration of the claim. If a plan has received all of the
155 information necessary to determine payer liability for a contested
156 claim and has not reimbursed a claim it has determined to be
157 payable within thirty (30) working days of the receipt
158 of that information, or if the plan is a health maintenance
159 organization, within forty-five (45) working days of receipt of
160 that information, interest shall accrue and be payable at a rate
161 of fifteen percent (15%) per annum beginning with the first

162 calendar day after the thirty (30) or forty-five (45) working day
163 period.

164 The obligation of the plan to comply with this section shall
165 not be deemed to be waived when the plan requires its medical
166 groups, independent practice associations or other contracting
167 entities to pay claims for covered services.

168 **SECTION 4.** (1) A health care service plan, including a
169 specialized health care service plan, shall reimburse each
170 complete claim, or portion thereof, whether in state or out of
171 state, as soon as practical, but no later than thirty (30) working
172 days after receipt of the complete claim by the health care
173 service plan, or if, the health care service plan is a health
174 maintenance organization, forty-five (45) working days
175 after receipt of the complete claim by the health care service
176 plan. However, a plan may contest or deny a claim, or portion
177 thereof, by notifying the claimant, in writing, that the claim is
178 contested or denied, within thirty (30) working days after receipt
179 of the claim by the health care service plan, or if the health
180 care service plan is a health maintenance organization, forty-five
181 (45) working days after receipt of the claim by the health care
182 service plan. The notice that a claim, or portion thereof, is
183 contested shall identify the portion of the claim that is
184 contested, by revenue code, and the specific information
185 needed from the provider to reconsider the claim. The notice that
186 a claim, or portion thereof, is denied shall identify the portion
187 of the claim that is denied, by revenue code, and the specific
188 reasons for the denial. A plan may delay payment of an
189 uncontested portion of a complete claim for reconsideration of a
190 contested portion of that claim so long as the plan pays those
191 charges specified in subsection (2) of this section.

192 (2) If a complete claim, or portion thereof, that is neither
193 contested nor denied, is not reimbursed by delivery to the
194 claimant's address of record within the respective thirty (30) or

195 forty-five (45) working days after receipt, the plan shall pay the
196 greater of fifteen dollars ($15.00) per year or interest at the
197 rate of fifteen percent (15%) per annum beginning with
198 the first calendar day after the thirty (30) or forty-five (45)
199 working day period. A health care service plan shall
200 automatically include the Fifteen Dollars ($15.00) per year or
201 interest due in the payment made to the claimant, without
202 requiring a request therefor.
203 (3) For the purposes of this section, a claim, or portion
204 thereof, is reasonably contested if the plan has not received the
205 completed claim. A paper claim from an institutional provider
206 shall be deemed complete upon submission of a legible emergency
207 department report and a completed UB 92 or other format adopted by
208 the National Uniform Billing Committee and reasonable relevant
209 information requested by the plan within thirty (30) working days
210 of receipt of the claim. An electronic claim from an
211 institutional provider shall be deemed complete upon submission of
212 an electronic equivalent to the UB 92 or other format adopted by
213 the National Uniform Billing Committee, and reasonable relevant
214 information requested by the plan within thirty (30) working days
215 of receipt of the claim. However, if the plan requests
216 a copy of the emergency department report within the thirty (30)
217 working days after receipt of the electronic claim from the
218 institutional provider, the plan may also request additional
219 reasonable relevant information within thirty (30) working days of
220 receipt of the emergency department report, at which time the
221 claim shall be deemed complete. A claim from a professional
222 provider shall be deemed complete upon submission of a completed
223 HCFA 1500 or its electronic equivalent or other format adopted by
224 the National Uniform Billing Committee, and reasonable relevant
225 information requested by the plan within thirty (30) working days
226 of receipt of the claim. The provider shall provide the

227 plan reasonable relevant information within ten (10) working days
228 of receipt of a written request that is clear and specific
229 regarding the information sought. If, as a result of reviewing
230 the reasonable relevant information, the plan requires further
231 information, the plan shall have an additional fifteen (15)
232 working days after receipt of the reasonable relevant information
233 to request the further information, notwithstanding any time limit
234 to the contrary in this section, at which time the claim shall be
235 deemed complete.
236 (4) This section shall not apply to claims about which there
237 is evidence of fraud and misrepresentation, to eligibility
238 determinations, or in instances where the plan has not been
239 granted reasonable access to information under the provider's
240 control. A plan shall specify, in a written notice sent to the
241 provider within the respective thirty (30) or forty-five (45)
242 working days of receipt of the claim, which, if any, of these
243 exceptions applies to a claim.
244 (5) If a claim or portion thereof is contested on the basis
245 that the plan has not received information reasonably necessary to
246 determine payer liability for the claim or portion thereof, then
247 the plan shall have thirty (30) working days or, if the health
248 care service plan is a health maintenance organization, forty-five
249 (45) working days after receipt of this additional information to
250 complete reconsideration of the claim. If a claim, or portion
251 thereof, undergoing reconsideration is not reimbursed by delivery
252 to the claimant's address of record within the respective thirty
253 (30) or forty-five (45) working days after receipt of the
254 additional information, the plan shall pay the greater of Fifteen
255 Dollars ($15.00) per year or interest at the rate of fifteen
256 percent (15%) per annum beginning with the first calendar day
257 after the thirty (30) or forty-five (45) working day period. A
258 health care service plan shall automatically include the Fifteen

259 Dollars ($15.00) per year or interest due in the payment made to
260 the claimant, without requiring a request therefor.

261 (6) The obligation of the plan to comply with this section
262 shall not be deemed to be waived when the plan requires its
263 medical groups, independent practice associations, or other
264 contracting entities to pay claims for covered services. This
265 section shall not be construed to prevent a plan from assigning,
266 by a written contract, the responsibility to pay interest and late
267 charges pursuant to this section to medical groups, independent
268 practice associations, or other entities.

269 (7) A plan shall not delay payment on a claim from a
270 physician or other provider to await the submission of a claim
271 from a hospital or other provider, without citing specific
272 rationale as to why the delay was necessary and providing a
273 monthly update regarding the status of the claim and the plan's
274 actions to resolve the claim, to the provider that submitted the
275 claim.

276 (8) A health care service plan shall not request or require
277 that a provider waive its rights pursuant to this section.

278 (9) This section shall not apply to capitated payments.

279 (10) This section shall apply only to claims for services
280 rendered to a patient who was provided emergency services and
281 care.

282 (11) This section shall not be construed to affect the
283 rights or obligations of any person pursuant to Section (3) of
284 this act.

285 (12) This section shall not be construed to affect a written
286 agreement, if any, of a provider to submit bills within a
287 specified time period.

288 **SECTION 5.** (1) A health care service plan shall not deny
289 payment of a claim on the basis that the plan, medical group,
290 independent practice association or other contracting entity did
291 not provide authorization for health care services that were

292 provided in a licensed acute care hospital and that were related
293 to services that were previously authorized, if all of the
294 following conditions are met:
295 (a) It was medically necessary to provide the services
296 at the time.
297 (b) The services were provided after the plan's normal
298 business hours.
299 (c) The plan does not maintain a system that provides
300 for the availability of a plan representative or an alternative
301 means of contact through an electronic system, including voicemail
302 or electronic mail, whereby the plan can respond to a request for
303 authorization within thirty (30) minutes of the time that a
304 request was made.
305 (2) This section shall not apply to investigational or
306 experimental therapies, or other noncovered services.
307 **SECTION 6.** (1) A health care service plan is prohibited
308 from engaging in an unfair payment pattern, as defined in this
309 section.
310 (2) Consistent with Section 8(1) of this act, the
311 Insurance Commissioner may investigate a health care service plan
312 to determine whether it has engaged in an unfair payment pattern.
313 (3) An "unfair payment pattern," as used in this section,
314 means any of the following:
315 (a) Engaging in a demonstrable and unjust pattern, as
316 defined by the department, of reviewing or processing complete and
317 accurate claims that results in payment delays.
318 (b) Engaging in a demonstrable and unjust pattern, as
319 defined by the department, of reducing the amount of payment or
320 denying complete and accurate claims.
321 (c) Failing on a repeated basis to pay the uncontested
322 portions of a claim within the time frames specified in Section 3
323 or 4 of this act.

324 (d) Failing on a repeated basis to automatically
325 include the interest due on claims under Section 3 of this act.
326 (4) (a) Upon a final determination by the Insurance
327 Commissioner that a health care service plan has engaged in an
328 unfair payment pattern, the Insurance Commissioner may:
329 (i) Impose monetary penalties as permitted under
330 this chapter.
331 (ii) Require the health care service plan for a
332 period of three (3) years from the date of the Insurance
333 Commissioner's determination, or for a shorter period prescribed
334 by the Insurance Commissioner, to pay complete and accurate
335 claims from the provider within a shorter period of time than that
336 required by Section 3 of this act. The provisions of this
337 subparagraph shall not become operative until January 1, 2006.
338 (iii) Include a claim for costs incurred by the
339 department in any administrative or judicial action, including
340 investigative expenses and the cost to monitor compliance by the
341 plan.
342 (b) For any overpayment made by a health care service
343 plan while subject to the provisions of this section, the provider
344 shall remain liable to the plan for repayment.
345 (5) The enforcement remedies provided in this section are
346 not exclusive and shall not limit or preclude the use of any
347 otherwise available criminal, civil or administrative remedy.
348 (6) The penalties set forth in this section shall not
349 preclude, suspend, affect or impact any other duty, right,
350 responsibility or obligation under a statute or under a contract
351 between a health care service plan and a provider.
352 (7) A health care service plan may not delegate any
353 statutory liability under this section.
354 (8) For the purposes of this section, "complete and accurate
355 claim" has the same meaning as that provided in the regulations
356 adopted by the department under Section 7(1) of this act.

357 (9) On or before December 31, 2006, the Department of
358 Insurance shall report to the Legislature and the Governor
359 information regarding the development of the definition of "unjust
360 pattern" as used in this section. This report shall include, but
361 not be limited to, a
362 description of the process used and a list of the parties involved
363 in the department's development of this definition as well as
364 recommendations for statutory adoption.
365 (10) The Department of Insurance shall make available upon
366 request and on its website, information regarding actions taken
367 under this section, including a description of the activities that
368 were the basis for the action.
369 **SECTION 7.** (1) The Department of Insurance shall, on or
370 before July 1, 2006, adopt regulations that ensure that plans have
371 adopted a dispute resolution mechanism pursuant to paragraph (h)
372 of Section 2 of this act. The regulations shall require that any
373 dispute resolution mechanism of a plan is fair, fast and cost
374 effective for contracting and noncontracting providers and define
375 the term "complete and accurate claim, including attachments and
376 supplemental information or documentation."
377 (2) On or before December 31, 2006, the department shall
378 report to the Governor and the Legislature its recommendations for
379 any additional statutory requirements relating to plan and
380 provider dispute resolution mechanisms.
381 **SECTION 8.** (1) Providers may report to the Department of
382 Insurance instances in which the provider believes a plan is
383 engaging in an unfair payment pattern.
384 (2) Plans may report to the Department of Insurance
385 instances in which the plan believes a provider is engaging in an
386 unfair billing pattern.
387 (a) "Unfair billing pattern" means engaging in a
388 demonstrable and unjust pattern of unbundling of claims, upcoding

389 of claims or other demonstrable and unjustified billing patterns,
390 as defined by the Department of Insurance.
391 (b) The Department of Insurance shall convene
392 appropriate state agencies to make recommendations by July 1,
393 2006, to the Legislature and the Governor for the purpose of
394 developing a system for responding to unfair billing patterns as
395 defined in this section. This system shall include a process by
396 which information is made available to the public regarding
397 actions taken against providers for unfair billing patterns and
398 the activities that were the basis for the action.
399 (3) On or before December 31, 2006, the department shall
400 report to the Legislature and the Governor information regarding
401 the development of the definition of "unfair billing pattern" as
402 used in this section. This report shall include, but not be
403 limited to, a description of the process used and a list of the
404 parties involved in the department's development of this
405 definition as well as recommendations for statutory adoption.
406 **SECTION 9.** This act shall take effect and be in force from
407 and after July 1, 2005.

ST: Health Care Services Plans; prohibit from engaging in unfair payment practices against physicians.