SB474

129286-1

By Senator Whatley

RFD: Banking and Insurance

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SYNOPSIS: This bill would establish a program for health care providers and certain health care insurers, health maintenance organizations, and other related entities to resolve claim disputes by allowing a third-party resolution organization to review and consider the claim dispute and make recommendations to the Department of Public Health regarding resolution of the claims.

This bill would also authorize the department to adopt rules to administer this program.

A BILL

TO BE ENTITLED

AN ACT

To provide for the establishment of a statewide claim-dispute-resolution program for health care providers and certain health insurers, health maintenance organizations, and

other related entities; and to provide rulemaking authority to the State Department of Public Health.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. (a) For the purposes of this section, the following words shall have the following meanings:

(1) DEPARTMENT. The State Department of Public Health.

(2) HEALTH BENEFIT PLAN. A health insurance policy, including a self-insured health plan, that covers hospital, medical, or surgical expenses, health maintenance organizations, preferred provider organizations, medical service organizations, physician-hospital organizations, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes health care services to patients, insureds, or beneficiaries in this state. The term includes, but is not limited to, entities created pursuant to Article 6 of Chapter 20 of Title 10A, Code of Alabama 1975.

(3) PROVIDER. A medical practitioner, dental practitioner, medical institution, physician, dentist, hospital, or other health care provider as the terms are defined in Section 6-5-481, Code of Alabama 1975.

(4) RESOLUTION ORGANIZATION. A qualified independent third-party claim-dispute-resolution entity selected by and contracted with the department.

(b)(1) The department shall establish a program by January 1, 2012, to provide assistance to providers and health

benefit plans for resolution of claim disputes that are not resolved by the provider and the health benefit plan. The department shall contract with a resolution organization to timely review and consider claim disputes submitted by providers and health benefit plans and recommend to the department an appropriate resolution of those disputes. The department shall establish by rule jurisdictional amounts and methods of aggregation for claim disputes that may be considered by the resolution organization.

(2) The resolution organization shall review claim disputes filed by providers and health benefit plans unless the disputed claim:

a. Is related to interest payment.

b. Does not meet the jurisdictional amounts or the methods of aggregation established by department rule, as provided in subdivision (1).

c. Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process.

d. Is related to a health benefit plan that is not regulated by the state.

e. Is part of a Medicaid fair hearing pursued under 42 C.F.R. §§ 431.220 et seq.

f. Is the basis for an action pending in state or federal court.

g. Is subject to a binding claim-dispute-resolution process provided by contract entered into prior to the

effective date of this act, between the provider and the health benefit plan.

(3) Contracts entered into or renewed on or after the effective date of this act may require exhaustion of an internal dispute-resolution process as a prerequisite to the submission of a claim by a provider or a health benefit plan to the resolution organization.

(4) A provider or health benefit plan may not file a claim dispute with the resolution organization more than 12 months after a final determination has been made on a claim by a health benefit plan or provider.

(5) The resolution organization shall require the health benefit plan or provider submitting the claim dispute to submit any supporting documentation to the resolution organization within 15 days after receipt by the health benefit plan or provider of a request from the resolution organization for documentation in support of the claim dispute. The resolution organization may extend the time if appropriate. Failure to submit the supporting documentation within such time period shall result in the dismissal of the submitted claim dispute.

(6) The resolution organization shall require the respondent in the claim dispute to submit all documentation in support of its position within 15 days after receiving a request from the resolution organization for supporting documentation. The resolution organization may extend the time if appropriate. Failure to submit the supporting documentation

within such time period shall result in a default against the health benefit plan or provider. In the event of a default, the resolution organization shall issue its written recommendation to the department that a default be entered against the defaulting entity. The written recommendation shall include a recommendation to the department that the defaulting entity shall pay the entity submitting the claim dispute the full amount of the claim dispute, plus all accrued interest, and shall be considered a nonprevailing party for the purposes of this section.

(7) a. If, on an ongoing basis during the preceding 12 months, the department has reason to believe that a pattern of noncompliance with Section 27-1-17, Code of Alabama 1975, exists on the part of a particular health benefit plan or provider, the department shall evaluate the information contained in these cases to determine whether the information evidences a pattern and report its findings, together with substantiating evidence, to the appropriate licensure or certification entity for the health benefit plan or provider.

b. In addition, the department shall prepare a report to the Governor and the Legislature by February 1 of each year, enumerating: Claims dismissed; defaults issued; and failures to comply with department final orders issued under this section.

(c) The department shall adopt rules to establish a process to be used by the resolution organization in considering claim disputes submitted by a provider or health

benefit plan which shall include the issuance by the resolution organization of a written recommendation, supported by findings of fact, to the department within 60 days after the requested information is received by the resolution organization within the timeframes specified by the resolution organization. In no event may the review time exceed 90 days following receipt of the initial claim dispute submission by the resolution organization.

(d) Within 30 days after receipt of the recommendation of the resolution organization, the department shall adopt the recommendation as a final order.

(e) The department shall notify within seven days the appropriate licensure or certification entity of a violation of a final order issued by the department pursuant to this section.

(f) The entity that does not prevail in the department's order shall pay a review cost to the review organization, as determined by department rule. The rule shall provide for an apportionment of the review fee in any case in which both parties prevail in part. If the nonprevailing party fails to pay the ordered review cost within 35 days after the department's order, the nonpaying party is subject to a penalty of not more than five hundred dollars ($500) per day until the penalty is paid.

(g) The department shall have the power to adopt rules to administer this section.

Section 2. This act shall become effective on the first day of the third month following its passage and approval by the Governor, or its otherwise becoming law.