State Corporation Commission
2004 Fiscal Impact Statement

1. Bill Number HB266

House of Origin ☒ Introduced ☐ Substitute ☐ Engrossed

Second House ☐ In Committee ☐ Substitute ☐ Enrolled

2. Patron Morgan

3. Committee Commerce and Labor

4. Title Insurance; prescription claims; mandated electronic funds transfers or automated clearinghouse transfers

5. Summary/Purpose: Requires each insurer, corporation or health maintenance organization (HMO) whose insurance policy, contract or plan includes out-patient prescription drug coverage to pay each prescription claim received via electronic claims transmission from a prescription benefit provider by electronic funds transfer or automated clearing house transfer within 30 days of receipt of the claim. The payment made by the insurer, corporation or HMO will be made to an account designated by the prescription benefit provider or its representative. Before the payment is made, the insurer, corporation or HMO shall provide documentation to the prescription benefit provider of claims payment information which identifies the individual claims that are included in the payment. The payment information shall be in a format mutually agreed upon by the insurer, corporation or HMO and the prescription benefit provider, and shall comply with federal guidelines enacted pursuant to the federal Health Insurance Portability and Accountability Act.

6. Fiscal Impact Estimates are unavailable (see Item 8)

7. Budget amendment necessary: No

8. Fiscal implications: HB 266 would necessitate revision by insurance carriers of all provider contracts and changes to their computer systems for payment and for notification requirements.

9. Specific agency or political subdivisions affected: State Corporation Commission Bureau of Insurance

10. Technical amendment necessary: The Bureau of Insurance offered several technical amendments to the patron of House Bill 266 as follows:

1. HB 266 conflicts with existing § 38.2-3407.15, the Ethics and Fairness in Carrier Business Practices statute, which requires, in subsection B 1, the payment of a "clean" claim within 40 days of receipt of the claim (30 days in HB 266). The requirement

specified in B 1 addresses both contractual language requirements and company procedural requirements.

It appears that a change to § 38.2-3407.15 B 1 would be necessary in order to avoid the conflict. Further, the Bureau suggested that the placement of the new requirement set forth in HB 266 at existing § 38.2-3407.4:2 may not be appropriate, as that section deals exclusively with prescription benefit cards.

The Bureau suggested that HB 266 be amended to strike the wording being added to § 38.2-3407.4:2, and instead amend existing § 38.2-3407.15 B 1 to achieve the purpose of the bill:

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim, except for claims received via electronic claims submission from a prescription benefit provider as set forth in subdivision 10 of this subsection, within forty days of receipt of the claim, where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

[No changes in subdivisions 2-9]…

10. For each payable prescription claim received via electronic claims transmission from a prescription benefit provider, the insurer, corporation, or health maintenance organization shall pay the prescription benefit provider by electronic funds transfer or automated clearing house transfer within 30 days of receipt of such claim. The payment by the insurer, corporation, or health maintenance organization shall be made to an account designated by the prescription benefit provider or its authorized representative. Prior to payment, the insurer, corporation, or health maintenance organization shall provide documentation to the prescription benefit provider of the claims payment information identifying the individual claims that are included in the payment. The claims payment information shall be in a format mutually agreed to by the insurer, corporation, or health maintenance organization and the prescription benefit provider, and shall comply with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 201 et seq.

11. Other comments: None

Date: 01/25/04 / V.Tompkins

cc: Secretary of Health and Human Resources