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## SENATE BILL NO. 1289

Offered January 13, 2021

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A *BILL to amend and reenact § 38.2-3407.15 of the Code of Virginia, relating to health insurance; carrier business practices; provider contracts.*

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Patron—Surovell

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Referred to Committee on Commerce and Labor

**Be it enacted by the General Assembly of Virginia:****1. That § 38.2-3407.15 of the Code of Virginia is amended and reenacted as follows:****§ 38.2-3407.15. Ethics and fairness in carrier business practices.**

A. As used in this section:

"Carrier," "enrollee," and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Codes" means, as applicable, *Physicians' Current Procedural Terminology identifying codes as published by the American Medical Association, Health Care Common Procedure Coding System codes as published by the National Uniform Billing Committee, diagnosis related group classifications, revenue codes, or other codes required or recognized by a carrier or included in any fee schedule in the provider contract.*

"Enrollee" means any person entitled to health care from a carrier.

"Fee schedule" means the complete fee schedule that is applicable to and will be a part of an existing or contemplated provider contract for all health care services to be provided by a provider under a provider contract. For purposes of this definition, a summary providing fees for a list of most commonly used codes or procedures performed by the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis is not a fee schedule, and no fee schedule shall be regarded as not being a complete fee schedule as a result of any code not being available and published by the source for that code at the time the fee schedule is presented to the provider.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by

59 reducing other payments currently owed to the provider, by withholding or setting off against future  
60 payments, or in any other manner reducing or affecting the future claim payments to the provider.

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

64 1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of  
65 the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by  
66 specific information available for review by the person submitting the claim that:

67 a. The claim is determined by the carrier not to be a clean claim due to a good faith determination  
68 or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the  
69 eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim,  
70 (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or  
71 (vi) the manner in which services were accessed or provided; or

72 b. The claim was submitted fraudulently.

73 Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The  
74 person submitting the claim shall be entitled to inspect such record on request and to rely on that record  
75 or on any other admissible evidence as proof of the fact of receipt of the claim, including without  
76 limitation electronic or facsimile confirmation of receipt of a claim.

77 2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from  
78 the person submitting the claim the information and documentation that the carrier reasonably believes  
79 will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt  
80 of the additional information requested under this subsection necessary to make the original claim a  
81 clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier  
82 may refuse to pay a claim for health care services rendered pursuant to a provider contract which are  
83 covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim  
84 of the matters identified above unless such failure was caused in material part by the person submitting  
85 the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of  
86 payment of such a claim if permitted by the provider contract unless such retroactive denial of payment  
87 of the claim would violate subdivision 7. Nothing in this subsection shall require a carrier to pay a  
88 claim which is not a clean claim.

89 3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any  
90 provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be  
91 paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

92 4. a. Every carrier shall establish and implement reasonable policies to permit any provider with  
93 which there is a provider contract (i) to confirm in advance during normal business hours by free  
94 telephone or electronic means if available whether the health care services to be provided are medically  
95 necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider  
96 (or to the type of health care services which the provider has contracted to deliver under the provider  
97 contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of  
98 a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c)  
99 provider-specific payment and reimbursement methodology, coding levels and methodology,  
100 downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and  
101 payment matters necessary to meet the terms and conditions of the provider contract, including  
102 determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or  
103 downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each  
104 provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website  
105 the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the  
106 provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider  
107 contract a telephone or facsimile number or e-mail address that a provider can use to request the specific  
108 bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or  
109 provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a  
110 provider, a carrier shall provide the requesting provider with such policies within 10 business days  
111 following the date the request is received.

112 b. Every carrier shall make available to such providers within 10 business days of receipt of a  
113 request, copies of or reasonable electronic access to all such policies which are applicable to the  
114 particular provider or to particular health care services identified by the provider. In the event the  
115 provision of the entire policy would violate any applicable copyright law, the carrier may instead  
116 comply with this subsection by timely delivering to the provider a clear explanation of the policy as it  
117 applies to the provider and to any health care services identified by the provider.

118 5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or  
119 has advised the provider or enrollee in advance of the provision of health care services that the health  
120 care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or

c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

7. No carrier ~~may~~ *shall* impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

8. Notwithstanding subdivision 7, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

9. No provider contract ~~may~~ *shall* fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid ~~which~~ *that* is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract. *Fee schedules shall be supplied in writing and made available in machine-readable electronic format, such as Comma Separated Value (CSV), at the time the provider contract is presented for execution or amendment or when updates to the fee schedule occur. When the provider contract includes multiple health plans offered by the carrier and such health plans have different fee schedules, the carrier shall provide the complete fee schedule applicable to the provider for each health plan in which the provider participates or is proposed to participate.*

10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract. *Any such amendment to a provider contract shall be presented in a manner as to allow the provider to easily identify the specific terms being proposed for amendment, which may include, as applicable, references to specific, identifiable section numbers or page numbers, or any other reasonable method of identifying the proposed amendment and its location relative to the existing agreement. Such proposed amendments may be shown by using features such as highlighting, bolding, or striking the proposed modification.*

11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by

182 providing a clear, written explanation of the policy as it applies to the provider.

183 12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make  
184 this information available to providers.

185 13. Provider contracts shall permit a provider a maximum of 90 days from the date a health care  
186 service is rendered to submit a claim for payment.

187 14. Provider contracts shall include provisions (i) requiring providers to provide health care services  
188 to enrollees in a manner similar to and within the same time availability in which the provider provides  
189 health care services to any other individual and (ii) prohibiting a provider from discriminating against  
190 any enrollee as a result of the enrollee's enrollment in a health plan, or on the basis of the enrollee's  
191 race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source,  
192 state of health, need for health care services, status as a litigant except in cases where the enrollee  
193 claims medical malpractice by the provider, status as a Medicare enrollee, status as a medical  
194 assistance recipient, sexual orientation, or gender identity, or on any other basis prohibited by law. No  
195 provider contract shall require a provider to provide any type or kind of health care service to enrollees  
196 that it does not customarily provide to others.

197 C. If the appropriate licensing authority receives a report that a provider has violated the provisions  
198 of subdivision B 14 by discriminating against an enrollee and the report is substantiated after  
199 investigation, such licensing authority may levy a fine upon the provider in an amount not to exceed  
200 \$1,000 per violation and may take other formal or informal disciplinary action as permitted under this  
201 chapter. In addition to the remedies provided in this subsection, upon notification of an alleged violation  
202 of the provisions of subdivision B 14, the Commission shall notify the appropriate licensing authority  
203 which shall have the authority to investigate and enforce any violations through appropriate means. Any  
204 enrollee who suffers loss or injury as the result of alleged discrimination in violation of subdivision B  
205 14 shall be entitled to initiate an action to recover the greater of statutory damages of \$500 or actual  
206 damages, and reasonable attorney fees.

207 D. Without limiting the foregoing, in the processing of any payment of claims for health care  
208 services rendered by providers under provider contracts and in performing under its provider contracts,  
209 every carrier subject to regulation by this title shall adhere to and comply with the minimum fair  
210 business standards required under subsection B, and the Commission shall have the jurisdiction to  
211 determine if a carrier has violated the standards set forth in subsection B by failing to include the  
212 requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has  
213 failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the  
214 performance of its provider contracts. No provider contract shall, directly or indirectly, (i) restrict the  
215 carrier from directing or steering enrollees to other health care providers; (ii) restrict the carrier from  
216 offering incentives to encourage enrollees to utilize specific providers; (iii) require the carrier to enter  
217 into any additional contract with an affiliate of the provider as a condition of entering into a contract  
218 with such provider; (iv) require the carrier to agree to payment rates or other terms for any affiliate not  
219 party to the contract of the provider involved; or (v) restrict other carriers not party to the contract  
220 from paying a lower rate for items or services than the contracting plan or issuer pays for such items  
221 or services.

222 ~~D.~~ E. No carrier shall be in violation of this section if its failure to comply with this section is  
223 caused in material part by the person submitting the claim or if the carrier's compliance is rendered  
224 impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection,  
225 strike, fire, or power outages) which are not caused in material part by the carrier.

226 ~~E.~~ F. Any provider or carrier who suffers loss as the result of a ~~carrier's~~ violation of this section or  
227 a ~~carrier's~~ breach of any ~~provider~~ contract provision required by this section shall be entitled to initiate  
228 an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a  
229 provider's or carrier's gross negligence and willful conduct, it may increase damages to an amount not  
230 exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the  
231 contrary, in addition to any damages awarded, such provider or carrier also may be awarded reasonable  
232 ~~attorney's~~ attorney fees and court costs. Any provider or carrier injured as a result of a violation or  
233 threatened violation of any provision of this section shall also be entitled to injunctive relief against any  
234 and all violators or persons threatening violation. Each claim for payment which is paid or processed in  
235 violation of this section or with respect to which a violation of this section exists shall constitute a  
236 separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this  
237 subsection.

238 F. G. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the  
239 employment or other contractual relationship with a provider, or any provider contract, or otherwise  
240 penalize any provider, for invoking any of the provider's rights under this section or under the provider  
241 contract. No provider shall terminate or fail to renew the contractual relationship with a carrier, or any  
242 provider contract, or otherwise penalize any carrier, for invoking any of the carrier's rights under this  
243 section or under the provider contract.

244     ~~G.~~ *H.* This section shall apply only to carriers subject to regulation under this title.  
245     ~~H.~~ *I.* This section shall apply with respect to provider contracts entered into, amended, extended or  
246 renewed on or after July 1, 1999.  
247     ~~I.~~ *J.* Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and  
248 regulations as it may deem necessary to implement this section.  
249     ~~J.~~ *K.* The Commission shall have no jurisdiction to adjudicate individual controversies arising out of  
250 this section.