MISSISSIPPI LEGISLATURE REGULAR SESSION 2012

By: Representative DeLano

To: Insurance; Public Health and Human Services

HOUSE BILL NO. 1413

AN ACT TO CREATE THE HONORING PATIENTS' ASSIGNMENT OF BENEFITS ACT; TO DEFINE CERTAIN TERMS USED IN THIS ACT; TO REQUIRE COVERED ENTITIES TO PAY BENEFITS TO A NONPARTICIPATING HEALTH CARE PROVIDER WHO RENDERS THE SAME SERVICE AS A PARTICIPATING HEALTH CARE PROVIDER THAT IS COVERED FOR PAYMENT UNDER THE HEALTH CONTRACT; TO REQUIRE THE NONPARTICIPATING PROVIDER TO PROVIDE WRITTEN NOTICE OF ASSIGNMENT OF BENEFITS; TO PRESCRIBE THE PROCESS BY WHICH PAYMENTS SHALL BE MADE; TO PENALIZE A COVERED ENTITY THAT FAILS TO MAKE TIMELY PAYMENTS; TO PRESCRIBE THE METHOD TO BE FOLLOWED TO CORRECT THE WRONGFUL PAYMENT OF BENEFITS; TO REQUIRE THAT NOTICE OF A DISPUTE REGARDING THE LEGITIMACY OF A CLAIM OR THE APPROPRIATE REIMBURSEMENT BE PROVIDED WITHIN A REASONABLE TIME AFTER RECEIPT OF THE CLAIM; TO PROVIDE THAT ACCEPTANCE OF AN ASSIGNMENT IS NOT AN ACCEPTANCE OF THE COVERED ENTITY'S FEE SCHEDULE; AND FOR RELATED PURPOSES.

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

SECTION 1. This act shall be known and may be cited as the "Honoring Patients' Assignment of Benefits Act."

SECTION 2. The Legislature hereby finds and declares that:

(a) Often a patient will see a health care provider and authorize, in writing, that a covered entity shall issue payment for services directly to the health care provider, whether or not the provider has a contract with the covered entity.

(b) Despite this authorization, however, a covered entity may fail to honor this valid "assignment of benefits" from the patient to the health care provider.

(c) While a covered entity may claim the lack of privity of contract between the covered entity and the provider as the reason for the refusal to honor these agreements, the reality is that these entities prohibit such assignments in order to create a market advantage for themselves.

(d) By doing so, the covered entity can pressure a nonparticipating health care provider into entering into a contract with the covered entity and thus, becoming a participating provider.

(e) As covered entities gain a greater economic advantage, the state has a strong public interest in ensuring that the covered entity is obliged to pay a health care provider directly, when a valid assignment of benefits exists. Not doing so will strengthen a covered entity's market power and allow it to pressure nonparticipating providers into entering into contracts with the covered entity, in order to ensure that the provider is paid for services rendered.

SECTION 3. As used in this act the following terms shall have the meaning ascribed to them in this section unless the context indicates otherwise:

(a) "Covered entity" includes, but is not limited to, any entity responsible for payment of health care services, including, but not limited to, all entities that pay or administer claims on behalf of other entities.

(b) "Assignment of benefits" means any written instrument executed by the participant, beneficiary, enrollee or such person's authorized representative which assigns to the treating physician or other health care provider the participant's, beneficiary's or enrollee's right to receive reimbursement for medical services or items rendered to the patient.

SECTION 4. (1) Whenever a covered entity issues a health care related contract that provides that any of its benefits are payable to a participating health care provider for services rendered, the covered entity shall be required to pay those benefits directly to any similarly licensed nonparticipating provider who has rendered such services, where the nonparticipating provider has a written assignment of benefits.

(2) Where a nonparticipating provider has a written assignment of benefits, the provider must provide written notice of that assignment to the covered entity.

(3) The covered entity shall be required to send such benefit payments directly to the provider who has the written assignment.

(4) When payment is made directly to the health care provider, the covered entity shall give written notice of such payment to the participant, beneficiary or enrollee, or such person's authorized representative.

(5) Any covered entity that does not comply with subsections (1) through (4) of this section shall pay five percent (5%) interest, compounded daily, accruing from the day after payment was due, on any and all amounts of the claim or claims that remain unpaid sixty (60) days after receipt of all documents reasonably needed to determine the claim.

(6) If an assignment of benefits is made, but the covered entity pays the benefits to the participant, beneficiary or enrollee, or such person's authorized representative, then the covered entity shall also pay those benefits to the provider of health care who received the assignment within thirty (30) days of receiving notice of the incorrect payment from the provider.

(7) Where there is a good faith dispute regarding the legitimacy of a claim, the appropriate amount of reimbursement or the authorization for the assignment of benefits, notice that a dispute exists shall be promptly furnished by the covered entity, to the physician or his or her authorized representative or to other provider upon receipt of the claim. In no event shall the notice of dispute be furnished to the physician more than fourteen (14) days after receipt of the claim.

(8) By accepting an assignment of benefits, the provider is not agreeing to accept the covered entity's fee schedule or

specific payment rate as payment in full, a partial payment or as the appropriate payment.

(9) Any contract provision violating this act shall be considered null and void.

SECTION 5. If any provision of this act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this act, and to this end the provisions of this act are hereby declared severable.

SECTION 6. This act shall take effect and be in force from and after its passage.