SENATE FILE NO. SF0127

Medicaid federal compliance-2

Sponsored by: Senate Labor, Health and Social Services Committee

A BILL

for

AN ACT relating to the Medical Assistance and Services Act; expanding the list of third party payors to which the department's right of subrogation attaches; providing that the department's right of subrogation supersedes other statutes; providing that third party payors, as a condition of doing business, cooperate as specified in satisfying the department's subrogation right; and providing for an effective date.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 42-4-204(a), (c)(intro), (iii), by creating a new paragraph (v) and by creating a new subsection (e) is amended to read:

42-4-204. Department subrogated to right of recovery of applicant or recipient; utilization of personal health insurance; insurance coverage of recipients.

(a) The department shall be subrogated to any right of recovery or indemnification arising from an accident or occurrence resulting in expenditures by the department, which an applicant or recipient of medical assistance or any legally liable party has against an insurer, ~~for the cost of~~ health insurer, self-insured plan, group health plan, service benefit plan, managed care organization, pharmacy benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for health care items or services, including but not limited to hospitalization, pharmaceutical services, physician services, nursing services and other medical services, not to exceed the amount expended by the department for the care and treatment of the applicant or recipient. An applicant or recipient or legally liable party, by the act of applying for, or recipient receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the department. The department shall inform an applicant of the assignments at

the time of application. In addition, any entitlements from a contractual agreement with an applicant or recipient or legally liable party, a state or federal program or a claim or action against any responsible third party for medical services, not to exceed the amount expended by the department, shall be so assigned. The entitlements shall be directly reimbursable to the department by third party payors. The department may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the medicaid program and providing services to an applicant or recipient, in order to assist the provider in obtaining payment for the services. A provider that has received an assignment from the department shall notify the insurer of the assignment upon rendering of services to the applicant or recipient. Failure to so notify the insurer shall render the provider ineligible for payment from the department. Once the insurer has been billed or notified the provider may not request payment through the medicaid program until a payment, denial or other explanation of benefits, not including mistakes in billing, is received from the insurer. The provider shall notify the department of any request by the applicant or recipient or his legally liable party or representative for billing information.

(c) ~~Notwithstanding the provisions of title 26, no~~ No individual ~~or~~ accident policy, group accident policy, health ~~or~~ policy, accident and health policy, ~~or~~ medical expense policy or medical service plan contract, delivered, issued for delivery or renewed in this state on or after July 1, 1995, and no self-insured plan, managed care policy or plan, pharmacy benefit management plan or policy or other policy or plan issued by any other party that is, by statute, contract or agreement legally responsible for payment of a claim for items or services, delivered, issued for delivery or renewed in this state on or after July 1, 2007, shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who received medical assistance under this chapter. This section shall supersede any statutory provision to the contrary. No such policy, plan or contract, when enrolling an individual, shall take into account the individual's eligibility for medical assistance under this chapter. This subsection applies to all such policies, plans and contracts issued by any person including, but not limited to:

(iii) A ~~health maintenance~~ managed care organization, pharmacy benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service;

(v) A self-insured plan.

(e) In addition to the separate requirements set forth in W.S. 42-4-205, all health insurers, including all self-insured plans, group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, shall agree, as a condition of doing business in the state of Wyoming, to:

(i) Provide, with respect to the individuals who are eligible for or are provided medical assistance by the department of health, information to determine the period during which the individual or the individuals' spouses or dependents may be or may have been covered by a health insurer and the nature of the coverage provided, including

the name and address of the insurer and identifying number of the plan, in a manner prescribed by the secretary;

(ii) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from another party for an item or service for which payment has been made under the state plan;

(iii) Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted not later than three (3) years after the date of the provision of such health care item or service; and

(iv) Agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim, if:

(A) The claim is submitted by the state within the three (3) year period beginning on the date on which the item or service was furnished; and

(B) Any action by the state to enforce its rights with respect to the claim is commenced within six (6) years of the state's submission of the claim.

Section 2. This act is effective July 1, 2007.

(END)