Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

State of Arkansas *As Engrossed: H3/6/07*
86th General Assembly A Bill
Regular Session, 2007 HOUSE BILL 1471

By: Representative Moore

For An Act To Be Entitled

AN ACT TO ENSURE THAT THIRD PARTIES THAT ARE LIABLE FOR MEDICAID COSTS PROVIDE REIMBURSEMENT TO THE MEDICAID PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO ENSURE THAT THIRD PARTIES THAT ARE LIABLE FOR MEDICAID COSTS PROVIDE REIMBURSEMENT TO THE MEDICAID PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 20-77-306 is amended to read as follows:

20-77-306. Liability of third parties to Department of Health and Human Services.

~~*All parties who were legally liable for any or part of any medical cost of an injury, disease, disability, or condition requiring medical treatment for which the Medicaid program, established by § 20-77-102 has paid, or has assumed liability to pay, shall be liable to the Department of Human Services for the amount of their liability to the extent that the department has paid or agreed to pay.*~~

(a) As used in this section:

(1) "Health insurer" means a commercial insurance company offering health or casualty insurance to individuals or groups including without limitation experience-rated insurance contracts and indemnity contracts that offer the following:

(A) Automobile insurance, including casualty, medical payment, uninsured motorist bodily injury coverage, and underinsured benefits

except benefits payable for or limited under the terms of the policy to property damage or wrongful death;

(B) A group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., as it existed on January 1, 2007;

(C) A health care plan as defined in § 23-76-102, or similar laws of another state;

(D) A health maintenance organization;

(E) A liability insurance plan;

(F) A hospital and medical service corporation as defined in § 23-75-101;

(G) A managed care organization;

(H) A company that offers or administers health or casualty insurance to individuals or groups;

(I) A profit or nonprofit prepaid plan offering either medical services or full or partial payment for services that are reimbursed by Medicaid;

(J) An organization administering health or casualty insurance plans, including self-insured and self-funded plans;

(K) Other parties that are by statute, contract, or agreement, legally responsible for payment of a health care item or service;

(L) A pharmacy benefits manager; and

(M) Workers' compensation;

(2) "Medicaid" means the medical assistance program established under § 20-77-101 et seq.; and

(3) "Third party" means an individual, an entity, or a program that is or may be liable to pay all or part of the expenditures for Medicaid services furnished by the Medicaid.

(b) A third party or health insurer that is legally liable for any medical cost of an injury, disease, disability, or condition requiring medical treatment for which Medicaid has paid, or has assumed liability to pay, shall be liable to reimburse Medicaid the lesser of:

(1) The difference between:

(A) The amount previously paid in good faith by a third party or health insurer to a recipient or health care provider for the medical cost of an injury, a disease, a disability; and

(B) The full amount of the liability of the third party or health insurer; or

(2) The full amount paid by Medicaid for the medical cost of an injury, a disease, or a disability.

(c) Upon request of the Department of Health and Human Services, a health insurer doing business in this state shall provide the department with eligibility and coverage information that will enable the department to determine:

(1) Which Medicaid recipients may be or may have been covered by the third party or health insurer;

(2) The period of the coverage;

(3) The coverage; and

(4) The name, address, and identifying number of the plan.

(d) A health insurer shall:

(1) Accept Medicaid's right of recovery and the assignment to Medicaid of the right of a Medicaid recipient or other entity for payment from the health insurer or a third party for an item or a service for which Medicaid has made payment;

(2) Subject to the time limits imposed under subdivision (d)(3) of this section and subsection (f) of this section, process and, if appropriate, pay Medicaid reimbursement claims to the same extent that the plan would have been liable had it been properly billed at the point of sale; and

(3) Agree not to deny claims submitted by the department based on a failure to:

(A) Present proper documentation of coverage at the point of sale; or

(B) The date of submission of the claim if the claim is submitted within three (3) years from the date on which the claimed item or service was furnished.

(e) The assignment to Medicaid of the right of a Medicaid recipient or other entity for payment from the third party or health insurer for an item or a service for which Medicaid has made payment occurs at the time the recipient requests an item or a service.

(f)(1) A health insurer shall respond to any inquiry by the department regarding claims submitted within three (3) years after the date on which the

item or service was furnished.

(2) The department shall begin an action to enforce Medicaid's rights with respect to a claim within six (6) years of the department's submission of the claim.

(g) Nothing in this subchapter requires a health insurer to reimburse Medicaid for items or services that Medicaid does not or did not cover for the recipient.

(h)(1) The department shall adopt rules necessary to implement this subchapter.

(2)(A) The rules shall:

(i) Conform to the Administrative Procedure Act.

(ii) Include provisions for contractual agreements between the department and health insurers specifying the procedures for data exchanges made under this subchapter.

/s/ Moore