HOUSE BILL REPORT
HB 1418

As Reported by House Committee On:
Financial Institutions & Insurance
Appropriations

Title: An act relating to regulating insurance overpayment recovery practices.

Brief Description: Regulating insurance overpayment recovery practices.

Sponsors: Representatives Kirby, Roach, Simpson, Santos, Campbell, Orcutt, Williams and Serben.

Brief History:
Committee Activity:
Financial Institutions & Insurance: 2/3/05, 2/22/05 [DPS];
Appropriations: 3/3/05 [DP2S(w/o sub FII)].

Brief Summary of Second Substitute Bill

- If a health carrier intends to retroactively deny, adjust, or seek recoupment or refund of a claim paid to a health care provider, the carrier must provide notice to the health care provider.
- A carrier may not seek to recover on a claim more than a year after the claim was filed unless coordination of benefits or fraud is involved.
- A carrier may not seek to recover on a claim more than 18 months after the claim was filed if coordination of benefits is involved.
- The provider may dispute the action of the carrier within 30 days of receiving the notice.
- The provider may file a revised claim, request a reconsideration, or, in the case of coordination of benefits, seek reimbursement from the entity responsible for payment within six months of receiving the notice.

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS & INSURANCE

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Kirby, Chair; Ericks, Vice Chair; Roach, Ranking Minority Member; Newhouse, Santos, Schual-Berke, Serben, Simpson and Williams.

Minority Report: Do not pass. Signed by 2 members: Representatives Tom, Assistant Ranking Minority Member; and Strow.

Staff: Jon Hedegard (786-7127).

Background:

Disability insurers, health care service contractors (HCSCs), and health maintenance organizations (HMOs) may periodically overpay for treatment of their enrollees when they reimburse the provider. The reimbursement overpayment may be due to an error or due to incorrect or incomplete information regarding the treatment or enrollee.

The Insurance Commissioner oversees disability insurers, HCSCs, and HMOs. This includes some statutes and administrative rules regarding contracts between health carriers and providers. The issue of overpayments and processes for insurer recovery of actual or alleged overpayments are not explicitly addressed in statute or administrative rule.

Health care provider is defined in current law as:

(a) a person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) an employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

Chapter 48.20 RCW regulates disability insurance.
Chapter 48.21 RCW regulates group and blanket disability insurance.
Chapter 48.44 RCW regulates health care service providers (HCSCs).
Chapter 48.46 RCW regulates health maintenance organizations (HMOs).

Summary of Substitute Bill:

Except for cases involving fraud or coordination of benefits, a health carrier may not retroactively deny, adjust, or seek recoupment or refund of a claim paid to a health care provider more than one year after the payment was made. In cases involving coordination of benefits, a health carrier may not retroactively deny, adjust, or seek recoupment or refund of a claim paid to a health care provider more than 18 months after the payment was made.

When a carrier retroactively denies, adjusts, or seeks recoupment or refund of a claim paid, it must provide notice to the health care provider, including information specifying the reason the action was taken. If a carrier bases its action on a medical necessity determination, level of service determination, coding error, or billing irregularity, the action must be reconciled to a specific claim.

The provider may dispute the action of the carrier within 30 days of receiving the notice, in which case no repayment is due until the provider has exhausted available legal remedies.

The provider has six months from the date the notice is received to file a revised claim, request a reconsideration, or, in the case of coordination of benefits, seek reimbursement from the entity responsible for payment.

The requirements in the bill may not be waived by the insurer or provider.

A carrier may recover amounts from a patient to a provider if the patient was not entitled to coverage and the carrier is barred from recovering under the bill.

Substitute Bill Compared to Original Bill:

The substitute bill adds a new section to 48.43 RCW replacing parallel sections in chapters 48.20, 48.21, 48.44, and 48.46 RCW. The substitute bill adds additional provisions to the recoupment process, including reciprocal provisions providing for carrier recoupment processes in addition to provider recoupment processes, that limit a provider's ability to seek adjustments to paid claims. The substitute bill applies the recoupment process to plans or benefits offered under chapters 41.05 RCW, 70.47 RCW, and 74.09 RCW. An effective date of January 1, 2006, is added.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date of Substitute Bill: The bill takes effect on January 1, 2006.

Testimony For: (In support) This bill addresses problems that have existed for years. There is no law establishing a time-line to resolve provider payment issues. There is no provision of law that requires adequate disclosure to a provider. Billing errors are unfortunate but they do happen. This bill requires carriers to resolve billing issues within 12 months. Similar provisions are fairly standard in contracts today. A law is more appropriate than contractual provisions. Carriers must provide adequate information so a provider can check records and respond to the inquiry. Carriers have disproportionate bargaining power and contractual provisions may not adequately protect providers. The bill ought to provide reciprocal provisions for providers and carriers, language is developed that provides reciprocity. The bill should go further and include Employment Retirement Income Security Act of 1974 (ERISA) plans. It could then be argued in court that the state is not preempted from regulating in this area. Medicare could be included. Personal injury protection (PIP) coverage that is offered in connection to automobile coverage should also be included in the bill.

(With concerns)
Parties usually try to resolve these types of issues by contract not by legislation. Carriers are stewards of health care premiums. These dollars should not be spent on improper, false, or uncovered health services. If a bill is necessary, it should provide true reciprocity. The issue is best handled in the contract process. The bill only impacts private health plans; if it is to go forward, it should include the public health plans. Including Medicare may pose problems, there are certain federal requirements. Medicare is often offered by health carriers operating

in multiple states. If a carrier must create a Washington-specific system, they may be less inclined to do business in Washington.

Testimony Against: None.

Persons Testifying: (In support) Lori Bielinski, Chiropractic Association; Brad Tower, Optometric Physicians of Washington; and Pat LePley, Washington State Trial Lawyers.

(With concerns) Ken Bertrand, Group Health; and Nancy Wildermuth, Regence Blue Shield and PacifiCare.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Financial Institutions & Insurance. Signed by 16 members: Representatives Sommers, Chair; Fromhold, Vice Chair; Cody, Conway, Darneille, Dunshee, Grant, Haigh, Hunter, Kagi, Kenney, Kessler, Linville, McDermott, McIntire and Miloscia.

Minority Report: Do not pass. Signed by 13 members: Representatives Alexander, Ranking Minority Member; Anderson, Assistant Ranking Minority Member; McDonald, Assistant Ranking Minority Member; Armstrong, Bailey, Buri, Clements, Hinkle, Pearson, Priest, Schual-Berke, Talcott and Walsh.

Staff: Nona Snell (786-7153).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Financial Institutions & Insurance:

The substitute bill removes state agencies from the restrictions on retroactive claims adjustment.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Second Substitute Bill: The bill takes effect on January 1, 2006.

Testimony For: The fiscal numbers are astonishing. Twenty million dollars annually from DSHS is a huge amount. To clarify, the 12 to 18 month window is the time from when a payment is made for a carrier or provider to reconcile numbers Fraud is exempt. If there is $20 million overpaid, could $20 million be underpaid?

The original bill did not include public plans, only private carriers. Providers are limited by contract to a 12 month period. We are asking for equal footing for providers and carriers.

Testimony Against: The Group Health Cooperative is a nonprofit health maintenance organization that is governed by its own consumers. It serves about 550,000 patients across the state. About 40 percent are public employees.

The bill would cost Group Health $6 million to $8 million in the first year and approximately $5 million annually thereafter. If 40 percent of enrollment are public employees, approximately $2.4 million annually would be added to bids for the basic health plan, state and local employee, school employee plans, and in consideration of the amount Group Health can lose with regard to Healthy Options care for Medicaid legislation. If public programs were taken out of the bill, there would still be added costs because of the way bids are done for the Basic Health Plan and other plans.

Regency Blue Shield's customer numbers are very similar to Group Health's numbers. Regency Blue Shield and Pacific Care also serve public employees. Prohibition from recuperating inappropriate billings will get passed along to the state. Whatever costs the state pays, the private sector also pays.

Blue Cross's numbers are similar to those of Group Health. Even if the bill is amended to exclude an impact to the state, it is still not a good idea. It is not playing fair with the private market and its importance and value to the state. The bill would create an unfair situation.

Overcharges is found several ways. Sometimes providers come back to insurers when they discover overcharging, or insurers often discover over billing in the second year after bills have been paid because of the audit process. It takes a while to see patterns of inappropriate billings.
The DSHS' Medical Assistance Administration (MAA) has developed a nationally recognized program for auditing and recovery. The DSHS is currently collecting more then $20 million annually, and must comply with state and federal regulations that require accounting for accurate billing. Twenty-seven thousand providers deliver services to MAA clients and are subject to audits and reviews. Restricting review and recovery will have a detrimentally impact to programs.

The fiscal note is being refined. At a minimum, the bill would cost DSHS $16 million in recoveries that would be lost annually. Eligibility determinations for newborn babies that qualify for SSI can take a significant amount. If the determination exceeds one year, there's a risk that we would not be able to recuperate those costs. Federally qualified health centers that are paid under provisional rates can take years to receive final settlement.

There are other fiscal impacts to DSHS and Medicaid programs that are being assessed, including third party liability.

The provisions for fraud are important, but many expenditures and overpayments are not fraud. Some are unintentional. There are methods in place to identify unintentional over billings. Some audits take six months to perform. To keep up, DSHS would have to have oversight staff located in large organizations. That is not in the best interest of DSHS or the provider.

Persons Testifying: (In support) Brad Tower, Optometric Physicians of Washington.

(Opposed) Ken Bertrand, Group Health; Nancy Wildermuth, Regence Blue Shield; Bob Covington, DSHS; and Rick Wickman, Premera Blue Cross.

Persons Signed In To Testify But Not Testifying: None.