HOUSE BILL REPORT
E2SHB 1418

As Amended by the Senate

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

Brief Description: Regulating insurance overpayment recovery practices.

Sponsors: By House Committee on Appropriations (originally sponsored by 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)].

Floor Activity:

Passed House: 3/11/05, 93-0.
Senate Amended.
Passed Senate: 4/11/05, 48-0.

Brief Summary of Engrossed Second Substitute Bill

- Limits a carrier or provider to two years after the claim was paid to retroactively deny, adjust, or seek recoupment or refund of a paid claim unless coordination of benefits or fraud is involved. If the carrier and provider agree, adjudicated claims may be adjusted after the two year limit from the date the claim was paid.
- Limits a carrier or provider to 30 months to retroactively deny, adjust, or seek recoupment or refund of a paid claim if coordination of benefits is involved. If the carrier and provider agree, adjudicated claims may be adjusted after 18 months from the date the claim was paid.
- Requires a carrier or provider to provide notice before retroactively denying, adjusting, or seeking recoupment or refund of a paid claim.
- Requires the carrier or provider to dispute the intended action of the opposite party within 30 days of receiving the notice.
- Allows a carrier or provider to file a revised claim, request a reconsideration, or response 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).

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).

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.

Summary of Engrossed Second Substitute Bill:

Except for cases involving fraud or coordination of benefits, a health carrier or provider may not retroactively deny, adjust, or seek recoupment or refund of a paid claim more than two

years after the payment was made. A carrier and provider may agree to adjust adjudicated claims after two years from the date the claim was paid.

In cases involving coordination of benefits, a health carrier or provider may not retroactively deny, adjust, or seek recoupment or refund of a paid claim more than 30 months after the claim was paid. A carrier and provider may agree to adjust adjudicated claims after 18 months from the date the claim was paid.

When a carrier or provider retroactively denies, adjusts, or seeks recoupment or refund of a paid claim, it must provide notice, including information specifying the reason the action was taken. A carrier or provider may dispute the action of the carrier within 30 days of receiving the notice. A carrier or provider has six months from the date the notice is received to file a revised claim, request a reconsideration, or response.

A carrier has one year to seek from the initial date a claim was paid to seek recoupment, adjustment or a refund if:
the carrier is seeking recovery of a claim payment owed by a third party as a consequence of liability owed by law; andthe carrier is unable to seek recovery directly from the third party because the third party has or will pay the provider for the same health service.
Any action that is based upon medical necessity determinations, level of service determinations, coding errors, or billing irregularities must be reconciled by the carrier or the provider to the specific claim in question.

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

EFFECT OF SENATE AMENDMENT(S):

The amendment reorganizes the bill. A section is created for the provisions that apply to health carriers and a separate section is created for the provisions that apply to health care providers. The term "refund" is defined. The amendment removes the 12 month limitation upon a carrier requesting a refund when a third-party payor is required to pay as a consequence of liability imposed by law. Provisions that required a carrier to contest the request of a refund by a provider within 30 days of the receipt of the request are removed. A subsection prohibiting the waiver of any provision is replaced by a section that states that the section prevails in any conflict with a contractual provision but allows a provider to choose to refund a previously made payment. Additional technical changes are made.

Appropriation: None.

Fiscal Note: Available.

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

Testimony For: (Financial Institutions & Insurance) (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)
Testimony For: (Appropriations) 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: (Financial Institutions & Insurance) 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.

Testimony Against: (Appropriations) 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: (Financial Institutions & Insurance) (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 Testifying: (Appropriations) (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: (Financial Institutions & Insurance) None.

Persons Signed In To Testify But Not Testifying: (Appropriations) None.