HOUSE BILL REPORT
E2SHB 1418

As Passed Legislature

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.
House Concurred.
Passed House: 4/19/05, 98-0.
Passed Legislature.

Brief Summary of Engrossed Second Substitute Bill

- Defines "refund" as the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.
- Limits a carrier's ability to request a refund to 24 months after the claim was paid, except in specified circumstances. Requires a provider to dispute a request within 30 days of receiving the request.
- Limits a carrier's ability to request a refund to 30 months after the claim was paid if coordination of benefits is involved. Requires a provider to dispute a request within 30 days of receiving the request.
- Prevents a carrier from requesting that a contested refund be paid any sooner than six months after receipt of a request for a refund.
- Limits a provider's ability to request an additional payment to 24 months after the claim was paid, except in specified circumstances.

- Limits a provider's ability to request an additional payment to 30 months after the claim was paid if coordination of benefits is involved.
- Prevents a provider from requesting an additional payment be made any sooner than six months after receipt of the request for additional payment.

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:

"Health carrier" (carrier) is defined in current law as:
a disability insurer regulated under chapter 48.20 or 48.21 RCW; a health care service contractor as defined in RCW 48.44.010; or a health maintenance organization as defined in RCW 48.46.020.
"Health care provider" (provider) is defined in current law as:
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; oran employee or agent of a person described above, acting in the course and scope of his or her employment.

A carrier may overpay or underpay a provider for treatment of an enrollee. The incorrect payment may be due to an error or due to incorrect or incomplete information regarding the treatment of enrollee.

Current law includes some statutes and administrative rules regarding contracts between carriers and providers. Processes for insurer recovery of actual or alleged overpayments and additional provider billing to achieve full payment are not explicitly addressed in statute or administrative rule.

Summary of Engrossed Second Substitute Bill:

"Refund" is defined as the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

General standards for a carrier request for a refund
Except in specified circumstances, a carrier may not:
request a refund unless it does so in writing to the provider within 24 months after the date that the payment was made; or request that a contested refund be paid any sooner than six months after receipt of the request.
A request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.
Carrier request for a refund related to a coordination of benefits
If a coordination of benefits is involved, a carrier may not:
request a refund from a health care provider of a payment unless it does so in writing to the provider within 30 months after the date that the payment was made; or request that a contested refund be paid any sooner than six months after receipt of the request.
Such a request must specify why the carrier believes the provider owes the refund and must include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.
Carrier request for a refund related to liability imposed by law
A carrier may at any time request a refund of a previously made if:
a third party is found responsible for satisfaction of the claim as a consequence of liability imposed by law; and the carrier is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

General standards for a provider request for additional payment
Except in the case of fraud or coordination of benefits, a provider may not:
request additional payment from a carrier to satisfy a claim unless he or she does so in writing to the carrier within 24 months after the date that the claim was denied or payment intended to satisfy the claim was made; or request that the additional payment be made any sooner than six months after receipt of the request.
A request must specify why the provider believes the carrier owes the additional payment.
Provider request for additional payment related to a coordination of benefits

If a coordination of benefits is involved, a provider may not:
request additional payment from a carrier to satisfy a claim unless he or she does so in writing to the carrier within 30 months after the date the claim was denied or payment intended to satisfy the claim was made; or request that the additional payment be made any sooner than six months after receipt of the request.
A request must specify why the provider believes the carrier owes the additional payment and must include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim.

Other provisions
The act prevails in any conflict with a provision in a contract between a carrier and a provider but a carrier may choose to make additional payments and a provider may choose to refund a previously made payment.

The act does not apply to claims for health care services provided through dental-only health carriers, health care services provided under Title XVIII (medicare) of the Social Security Act, or medicare supplemental plans regulated under chapter 48.66 RCW.

The act applies to contracts issued or renewed on or after January 1, 2006.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of session in which bill is passed.

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.