H-2006.1

SUBSTITUTE HOUSE BILL 1418

State of Washington 59th Legislature 2005 Regular Session

By House Committee on Financial Institutions & Insurance (originally sponsored by Representatives Kirby, Roach, Simpson, Santos, Campbell, Orcutt, Williams and Serben)

READ FIRST TIME 02/24/05.

1 AN ACT Relating to regulating insurance overpayment recovery
2 practices; amending RCW 41.05.017 and 70.47.130; adding a new section
3 to chapter 48.43 RCW; adding a new section to chapter 74.09 RCW; and
4 providing an effective date.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW
7 to read as follows:
8 (1) A carrier may not retroactively deny, adjust, or seek
9 recoupment or refund of a paid claim submitted by a health care
10 provider for any reason, other than fraud or coordination of benefits
11 or as set forth in subsection (5) of this section, after the expiration
12 of one year from the date the initial claim was paid. If a carrier
13 retroactively denies, adjusts, or seeks recoupment or refund of a paid
14 claim, the health care provider has an additional period of six months
15 from the date the notice required by subsection (6) of this section was
16 received within which to file either a revised claim or a request for
17 reconsideration supported by additional medical records or information.
18 (2) A health care provider may not retroactively seek adjustment of
19 a claim payment by a carrier for any reason, other than fraud or

coordination of benefits, after the expiration of one year from the date the initial claim was paid. If a provider retroactively seeks an adjustment of a paid claim, the carrier has an additional period of six months from the date the notice required by subsection (6) of this section was received within which to file a response.

(3) A carrier may not retroactively deny, adjust, or seek recoupment or refund of a paid claim submitted by a health care provider for reasons related to coordination of benefits with another carrier or other entity responsible for payment of the claim after the expiration of eighteen months from the date the original claim was paid by the primary or secondary payer, regardless who is seeking the adjustment or recoupment. A carrier may not unreasonably delay initial payment of a claim to a health care provider because of carrier efforts to coordinate benefits nor may a carrier require the provider to assume responsibility for coordination of benefits except to provide the carrier information. If the carrier retroactively denies, adjusts, or seeks recoupment or refund of a paid claim based on coordination of benefits, the carrier must provide the health care provider with notice specifying the reason for the denial, adjustment, recoupment, or refund, and provide the name and address of the entity that has acknowledged responsibility for payment of the denied claim. The health care provider has an additional six months from the date the health care provider received the notice specified in this subsection to submit a claim for reimbursement for the health care service to the carrier, medical assistance program, government health benefit program, or any other entity responsible for payment of services provided.

(4) A health care provider may not retroactively seek adjustment of a claim payment by a carrier for reasons related to coordination of benefits with another carrier or other entity responsible for payment of the claim after the expiration of eighteen months from the date the original claim was paid. If a provider retroactively seeks adjustment of a paid claim based on coordination of benefits, the health care provider must provide the carrier with notice specifying the reason for the adjustment, and provide the name and address of the entity that has failed to acknowledge responsibility for payment of the claim. The carrier has an additional six months from the date the carrier receives the notice specified in this subsection to respond.

1 (5) To prevent duplicate recovery for the same health service, a
2 carrier may seek recoupment, adjustment, or refund of a claim paid to
3 a health care provider after the expiration of one year from the date
4 the initial claim was paid if: (a) The carrier is seeking recovery of
5 a claim payment owed by a third party, including government entities,
6 as a consequence of liability imposed by law, such as that arising from
7 tort liability; and (b) the carrier is unable to seek recovery directly
8 from the third party because the third party either has paid or will
9 pay the provider for the same health service as the initial claim.
10 (6) A carrier or health care provider that retroactively denies,
11 adjusts, or seeks recoupment, adjustment, or refund of a paid claim
12 must give the other party written notice specifying the reason for the
13 action taken. Any actions that are based upon medical necessity
14 determinations, level of service determinations, coding errors, or
15 billing irregularities must be reconciled by the carrier or the
16 provider to the specific claims in question.
17 (7) A health care provider or a carrier has thirty days after
18 receipt of the notice under subsection (6) of this section in which to
19 notify the other party that they are disputing or contesting the
20 action. When a provider or a carrier fails to respond in writing in
21 thirty days to a written notice of recoupment or adjustment, the
22 carrier or provider may consider the recoupment or adjustment accepted.
23 If the health care provider or a carrier disputes or contests the
24 action, then any disputed or contested claim payment is not subject to
25 recoupment, refunds, or adjustment by the other party until all the
26 appeals procedures, hearings, or other remedies available to the health
27 care provider and the carrier have been finally decided. If the
28 decision is favorable to the carrier, any disputed payment may be
29 offset in a future claim payment for that provider.
30 (8) The requirements of this section may not be waived by contract
31 or otherwise by the health care provider or carrier. This section
32 neither permits nor precludes a carrier from recovering from a
33 subscriber, enrollee, or beneficiary any amounts paid to a health care
34 provider for benefits to which the subscriber, enrollee, or beneficiary
35 was not entitled under the terms and conditions of the health plan,
36 insurance policy, or other benefit agreement.
37 (9) This section does not apply to carrier or provider payment or
38 recoupment practices with respect to claims or payments for health care

services under health plans providing only dental coverage, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW.

(10) This section applies to:

(a) Health benefits offered under chapter 41.05 RCW;

(b) The basic health plan under chapter 70.47 RCW; and

(c) Health benefits offered under RCW 74.09.520.

Sec. 2. RCW 41.05.017 and 2000 c 5 s 20 are each amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 43.70.235, 48.43.545, 48.43.550, section 1 of this act, 70.02.110, and 70.02.900.

Sec. 3. RCW 70.47.130 and 2004 c 115 s 2 are each amended to read as follows:

(1) The activities and operations of the Washington basic health plan under this chapter, including those of managed health care systems to the extent of their participation in the plan, are exempt from the provisions and requirements of Title 48 RCW except:

(a) Benefits as provided in RCW 70.47.070;

(b) Managed health care systems are subject to the provisions of RCW 48.43.022, 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 43.70.235, 48.43.545, 48.43.550, 70.02.110, and 70.02.900;

(c) Persons appointed or authorized to solicit applications for enrollment in the basic health plan, including employees of the health care authority, must comply with chapter 48.17 RCW. For purposes of this subsection (1)(c), "solicit" does not include distributing information and applications for the basic health plan and responding to questions; ((~~and~~))

(d) Amounts paid to a managed health care system by the basic health plan for participating in the basic health plan and providing health care services for nonsubsidized enrollees in the basic health plan must comply with RCW 48.14.0201; and

(e) Under section 1 of this act.

1 (2) The purpose of the 1994 amendatory language to this section in
2 chapter 309, Laws of 1994 is to clarify the intent of the legislature
3 that premiums paid on behalf of nonsubsidized enrollees in the basic
4 health plan are subject to the premium and prepayment tax. The
5 legislature does not consider this clarifying language to either raise
6 existing taxes nor to impose a tax that did not exist previously.

7 NEW SECTION. **Sec. 4.** A new section is added to chapter 74.09 RCW
8 to read as follows:
9 Health benefits offered under RCW 74.09.520 are subject to section
10 1 of this act.

11 NEW SECTION. **Sec. 5.** This act takes effect January 1, 2006.

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