Approved: February 18, 2008
Date

MINUTES OF THE HOUSE INSURANCE AND FINANCIAL INSTITUTIONS COMMITTEE

The meeting was called to order by Chairman Clark Shultz at 3:30 P.M. on February 13, 2008 in Room 527-S of the Capitol.

All members were present except:
Representative Tom Burroughs- excused
Representative Brenda Landwehr- excused
Representative Cindy Neighbor- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Bruce Kinzie, Revisor of Statutes Office
Ken Wilke, Revisor of Statutes Office

Conferees appearing before the committee:
John Meetz, Kansas Department of Insurance
Bill Sneed, AHIP, America's Health Insurance Plans

Others attending:
See attached list.

Hearing on:
HB 2699 Providing time period for insurance company to recoup certain erroneously made payments.

Melissa Calderwood, Legislative Research Department, provided a brief overview on **HB 2699**.

Proponents:

John Meetz, Kansas Department of Insurance, (Attachment #1), presented testimony before the committee in support of **HB 2699**.

William W. Sneed, America's Health Insurance Plans, (Attachment #2), gave testimony before the committee in support of **HB 2699**.

Dan Morin, Director of Government Affairs, Kansas Medical Society, (Attachment #3), appeared before the committee in support of **HB 2699**.

Hearing closed on **HB 2699**.

Discussion and action on:

HB 2689 Insurance; risk-based capital requirements

Representative Dillmore moved **HB 2689** be passed and placed on Consent Calendar. Seconded by Representative Anthony Brown. Motion carried.

Next meeting will be Monday, February 18, 2008, 3:30 PM. In Room 527-S.

Meeting adjourned.

Insurance and Financial Institutions Committee
Guest Sign In Sheet
Tuesday, February 13 , 2008

Name	Representing
Rick Wilborn	Farmers Alliance
Bob Williams	Ks. Assoc of Osteopathic Medicine
Dan Morin	KS Medical Society
John Meetz	KID
John Campbell	KID
Lori Church	KAPCIC
Bill Brady	Capitol Strategies
Alex Kotoyantz	P.I.A.
Bill Sneed	AHIP
Jonathan Stokes	KAJ
Natalie Haag	Security Benefit

Kansas Insurance Department
Sandy Praeger, Commissioner of Insurance

TESTIMONY ON
HB 2699

HOUSE INSURANCE AND FINANCIAL INSTITUTIONS
February 13, 2008

Mr. Chairman and Members of the Committee;

I would like to thank you for the opportunity to appear today in support of House Bill 2699. When an insurance company makes a payment to a provider that is in error they currently have the ability to recoup that payment at any time within five years. This practice causes serious problems for providers especially as it pertains to their taxes and financial planning.

I want to make it clear that we have no problem when insurers recoup erroneous payments. But we feel it is incumbent upon insurers to discover and report their errors in a timely fashion. HB 2699 proposes a 15 month window for insurers to recoup any payments made in error. We feel this gives an insurer ample time to discover when a miscalculation has been made and to take corrective action. The 15 months is also a reflection of the amount of time a provider has to make a claim pursuant to K.S.A. 40-2203.

The Insurance Department has been in discussions with the industry on this legislation and as a result we would like to introduce a couple amendments to the bill. Originally, bill was written to include a 15 month provision for both the Accident and Health Prompt Pay Law and the Long Term Care Prompt Pay Law. Long Term Care providers have not experienced the same problems that have been experienced by those providers that provide for services covered by accident and health insurance. Therefore, we would propose that the statute of limitation on the recoup of erroneous long term care payments is unnecessary and should be stripped from the bill.

The second amendment we would like to propose is an exception to the 15 month statute of limitations in the event of fraud. The attached balloon makes it clear that in instances of fraud, the statute of limitations will not be governed by this amendment but rather by the provisions spelled out in K.S.A. 60-513. This would allow for companies to recoup payments made based on fraud for a period of two years from whenever the fraud was discovered or should have been discovered.

Mr. Chairman with the proposed amendments I would urge the committee to consider House Bill 2699 and recommend it favorable for passage. Thank you for the opportunity to appear today I would now stand for questions.

John Meetz
Government Affairs Liaison

House Insurance
Date: 2-13-08
Attachment # 1

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such interest.

(c) After receiving a request for additional information, the person claiming reimbursement shall submit all additional information requested by the insurer within 30 days after receipt of the request for additional information. Failure to furnish such additional information within the time required shall not invalidate nor reduce the claim if it was not reasonably possible to give such information within such time, provided such proof is furnished as soon as possible as defined (within the time prescribed) in paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto.

(d) Within 15 days after receipt of all the requested additional information, an insurer issuing a policy of accident and sickness insurance shall pay a clean claim in accordance with this section or send a written or electronic notice that states:

(1) Such insurer refuses to reimburse all or part of the claim; and

(2) specifies each reason for denial. Any insurer issuing a policy of accident and sickness insurance that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the rate of 1% per month.

(e) The provisions of subsection (b) shall not apply when there is a good faith dispute about the legitimacy of the claim, or when there is a reasonable basis supported by specific information that such claim was submitted fraudulently.

(f) In the event that an insurer erroneously pays a claim providing benefits to which the insured person or provider is not entitled, the insurer shall not initiate a request for reimbursement or refund of that erroneous payment, or in any other way seek to recoup the erroneous payment, unless such action is initiated within 15 months after the end of the month in which the erroneous payment was made.

~~(f)~~ *(g)* Any violation of this act by an insurer issuing a policy of accident and sickness insurance with flagrant and conscious disregard of the provisions of this act or with such frequency as to constitute a general business practice shall be considered a violation of the unfair trade practices act in K.S.A. 40-2401 et seq. and amendments thereto.

~~(g)~~ *(h)* The commissioner of insurance shall adopt rules and regulations necessary to carry out the provisions of the Kansas health care prompt payment act.

Sec. 3. K.S.A. 40-2442 and K.S.A. 2007 Supp. 40-2228h are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

In cases of fraud by the insured person or provider such action may be initiated within the applicable statute of limitations pursuant to K.S.A. 60-513.

Polsinelli

Shalton | Flanigan | Suelthaus PC

Memorandum

TO: THE HONORABLE CLARK SHULTZ, CHAIRMAN
HOUSE INSURANCE AND FINANCIAL INSTITUTIONS COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
AMERICA'S HEALTH INSURANCE PLANS

RE: H.B. 2699

DATE: FEBRUARY 13, 2008

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent America's Health Insurance Plans ("AHIP"). AHIP is a trade association representing nearly 1,300 member companies providing health insurance coverage to more than two million Americans. Our member companies offer medical expense insurance, long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers. We are here today to present testimony in support of H.B. 2699, but would request some amendments to the proposal.

We have been meeting with the Kansas Insurance Department regarding the original language of H.B. 2699. As you can see, this is an amendment to the Long-term Care Prompt Payment Act, and in discussions with the Department it was agreed that the amendment they are looking for really deals with the Health Care Prompt Payment Act, found at K.S.A. 40-2404, *et seq.* It is our understanding the Department is presenting today a balloon amendment which would remove the proposed amendment from the Long-term Care Prompt Payment Act and amend K.S.A. 40-2442, as that was their original intent. Thus, I am basing my testimony on the belief that the Department's proposed balloon will amend K.S.A. 40-2442 and that the amendment will be similar to the amendment proposed in H.B. 2669.

AHIP has strongly support prompt payment legislation, as it was involved in the original law passed in Kansas in 2000. AHIP has continued to work on fine-tuning the law for the benefit of the Kansas consumer. It is our understanding that the Department wishes to limit the ability of an insurer to go back to offset and/or correct a claim overpayment. In general, we do not have a problem with these types of statutes, but the amendment the Department has proposed does cause us some concern as it relates to consistency throughout the United States; thus, we would request the following changes.

We would request that the time period be changed from 15 months to 18 months. Our review of the laws in those states that have a time limit to make claims for offsets and/or

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House Insurance
Date: 2-13-08
Attachment # 2

corrections is generally 18 months. As a side note, we would note there are other states that have shorter time periods, but those states also have an extensive procedure by which that time can be extended. If the Committee so desires, we would be happy to provide language for such a mechanism.

Secondly, we would request that there be an exception to the time limit if there was fraud or misrepresentation involved in the erroneous payment. Again, our review of the various states indicates that all states that have this provision include some type of provision that excludes fraud from the limitation.

Finally, most states' statutes have additional language that allows an insurer/payor to make application to the Commissioner for an exception to the time limitation if the Commissioner finds it is in the best interest of the public to allow such exception.

We believe the above suggestions will create a statutory structure consistent with other states that have similar laws and that will allow insurance carriers that do business in multiple jurisdictions the ability to apply their policies on a consistent basis throughout the country.

With those recommendations, we would respectfully request that the Committee pass the bill out favorably.

I am available for other questions at your convenience.

Respectfully submitted,

William W. Sneed

WWS:kjb

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To: House Committee on Insurance & Financial Institutions

From: Dan Morin
Director of Government Affairs

Date: February 13, 2008

Subject: HB 2699; AN ACT concerning insurance; relating to time limits in which insurers can recoup certain erroneously made payments

The Kansas Medical Society appreciates the opportunity to comment in support of HB 2699, which establishes a maximum time limit on attempts by a health plan to recoup overpayments from providers.

Currently, it is possible for a Kansas physician to be continually exposed to refund for every insurance payment on every claim paid. HB 2699 addresses the need for closure on the issue of payments. Frequently, overpayments are the result of minor clerical errors made in the billing office, such as the transposition of billing code numbers, and involve only nominal amounts. At times, however, overpayments are the result of systematic billing errors, such as the repeated use of an incorrect billing code or improper application of insurance coverage prerequisites. Often, physicians do not know if they have been overpaid for a particular billing code, because some insurers do not routinely disclose to practices what they pay for all billing codes. To subject a health care provider to possible refund liability in excess of 15 months if the insurer later discovers a alleged mistaken overpayment, would be to place an undue administrative burden on the provider's practice especially when, more often than not, the provider made no misrepresentations and had no knowledge of the mistake when s/he accepted payment. Establishing the legitimacy of a refund request requires determining whether the payment made by the insurer truly was erroneous. The internal administrative review process can be a significant drain on the financial resources of the targeted provider. Such reviews also divert attention of key personnel from their usual activities.

Some reasons for an erroneous payment include; payment was made for an uninsured patient; the payment was made for services or supplies not covered under the benefit plan; the payment was greater than the amount owed; or the insurer was not the payer obligated to make the payment. If the payment was not made under such examples, the payment may not be erroneous, and a refund request may be disputed. If the procedure in question occurred over 15 months past; the provider may no longer be possible to submit claims to secondary or tertiary sources of payment to make up the loss incurred by returning the payment; it may be too late for the provider to seek another source of payment, such as medical assistance; or the provider may be unable to locate the patient to collect payment.

HB 2699 includes a reasonable time limit for carriers to seek repayment and we urge members to pass the bill favorably out of committee. Thank you for attention to our comments.

House Insurance
Date: 2-13-08
Attachment # 3