HOUSE BILL REPORT
HB 1826

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to medical benefits.

Brief Description: Modifying provisions affecting medical benefits.

Sponsors: Representatives Seaquist, Hinkle, Morrell, Moeller and Ormsby; by request of Department of Social and Health Services.

Brief History:
Committee Activity:
Health Care & Wellness: 2/15/07, 2/26/07 [DPS].

Brief Summary of Substitute Bill

- Requires health insurers, as a condition of doing business in Washington, to agree to specified coordination of benefits requirements with respect to recipients of state medical assistance, including responding to requests for information from the Department of Social and Health Services (DSHS) and not denying the DSHS claims for payment on procedural grounds.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 13 members: Representatives Cody, Chair; Morrell, Vice Chair; Hinkle, Ranking Minority Member; Alexander, Assistant Ranking Minority Member; Barlow, Campbell, Condotta, Curtis, Green, Moeller, Pedersen, Schual-Berke and Seaquist.

Staff: Chris Cordes (786-7103).

Background:

State Medical Assistance Programs

Medical assistance is available to eligible low-income state residents and their families from the Department of Social and Health Services (DSHS), primarily through the Medicaid program. Most of the state medical assistance programs are funded with matching federal

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funds in various percentages. Federal funding for the Medicaid program is conditioned on the state having an approved Medicaid state plan and related state laws to enforce the plan.

Coordination of Benefits with Liable Third Parties

If a recipient of state medical assistance is also covered by another health care plan (a third party plan), the recipient is a joint beneficiary. The third party is liable for payment of the recipient's health care services or items covered by its plan and paid for by the DSHS. States are required to have these coordination of benefits provisions in their Medicaid state plan, and to have laws in effect, under which the state acquires the right to those payments from any liable third party.

Washington's coordination of benefits statute requires insurers (commercial insurance companies providing disability insurance, health care service contractors, health maintenance organizations, and employers and unions providing self-insured health coverage) to use information provided by the DSHS to identify joint beneficiaries. The state must have common computer standards for sharing this information. Proper safeguards are required to protect the information.

The Deficit Reduction Act of 2005

The federal Deficit Reduction Act of 2005 (DRA) made several changes regarding the way in which third party liability is enforced for health care items or services provided to joint beneficiaries under the Medicaid program. The DRA added to the list of liable third parties and requires the states to have laws under which third parties, as a condition of doing business, agree to certain requirements.

Liable Third Parties. The list of liable third party health insurers expressly includes health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are legally responsible for payment of a claim for a health care item or service.

Conditions of Doing Business. States must have laws in effect that require health insurers, as a condition of doing business in the state, to:

(1) provide, at the request of the DSHS, eligibility and coverage information for individuals or their family members who are eligible for or have been provided Medicaid benefits;
(2) accept the DSHS's right to recovery, and to assignment of an individual's right to payment, for a health care item or service for which payment was made under the Medicaid program;
(3) respond to inquiries from the DSHS regarding payment for a health care item or service submitted within three years after the date; and
(4) agree not to deny a claim on procedural grounds (date, claim form format, or failure to present proper documentation at the point-of-sale) if the DSHS submitted the claim within the three-year period and took action to enforce its rights within six years.

Effective Date for State Laws to Comply. These changes under the DRA took effect January 1, 2006. For Washington, the DRA requires a complying law to be in effect by the first calender quarter after the close of the 2007 legislative session.

Summary of Substitute Bill:

Legislative Intent

The stated legislative intent of the coordination of benefits law is amended to recognize that health insurers need to increase efforts to share information as a condition of doing business in Washington and that the process for sharing information between the DSHS and the health insurers should be simplified.

Requirements for Third Party Health Insurers

As a condition of doing business in Washington, health insurers must:

(1) provide, at the request of the DSHS, eligibility and coverage information for individuals or their family members who are eligible for or have been provided state medical assistance;
(2) accept the DSHS's right to recovery, and to assignment of an individual's right to payment, for a health care item or service for which payment was made under state medical assistance;
(3) respond to inquiries from the DSHS regarding payment for a health care item or service submitted within three years after the date;
(4) agree not to deny a claim on procedural grounds (date, claim form format, or failure to present proper documentation at the point-of-sale) if the DSHS submitted the claim within the three-year period and took action to enforce its rights within six years; and
(5) agree to reasonable attorneys' fees and collection fees and costs for the prevailing party in an enforcement action.

Definitions

Several definitions are amended. "Health coverage" refers to health care items and services, rather than medical services, provided or paid for by a health insurer. "Health insurer" means any party that is legally responsible to pay a claim for a health care item or service, including these additional parties: private insurers, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or third party administrators.

The definition of "joint beneficiary" is amended to delete a reference to Washington residency.

Substitute Bill Compared to Original Bill:

The substitute bill makes various technical changes, including: (1) clarifying the definitions of "health insurance coverage" and "health insurer" to standardize them, while meeting federal requirements; (2) replacing references to the Medical Assistance Administration with

the DSHS; and (3) limiting attorneys' fees to "reasonable" attorneys' fees. The substitute bill also adds an emergency clause with a July 1, 2007, effective date.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill contains an emergency clause and takes effect July 1, 2007.

Staff Summary of Public Testimony:

(In support) Coordination of benefits under the state's medical assistance program must remain in compliance with the federal Deficit Reduction Act (DRA). The intent of the federal and state laws is to prevent duplication of payments when a recipient is covered by both the state and a third party, such as a private insurer. The DRA is very specific about the third parties that must be subject to this coordination of benefits. Third parties include third party administrators and other fiscal intermediaries. The DRA also applies to Employee Retirement Income Security Act plans, but not to Medicare recipients. Under the DRA, insurers cannot deny recovery based on the format of the request or procedural requirements. The DRA requires states to adopt these provisions.

(In support with amendment) The bill should exempt fixed indemnity payments when the insurer is not the primary coverage. Policies like American Family Life Assurance Company (AFLAC) pay the recipient, not a provider, on the occurrence of the covered event.

(Opposed) None.

Persons Testifying: (In support) Andy Renggli, Department of Social and Health Services.

(In support with amendment) Tim Boyd, American Family Life Assurance Company of Columbus.

Persons Signed In To Testify But Not Testifying: None.