BUSINESS & LABOR 5

EXHIBIT NO. 5
DATE 3/8/05
BILL NO. HB156

MONTANA STATE AUDITOR

JOHN MORRISON
STATE AUDITOR

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

March 7, 2005

Dear Senator Cocchiarella and Members of Senate Business and Labor Committee:

Re: HB 156

Thank you for this opportunity to provide more information about HB 156 to respond to questions the committee asked during the hearing Friday, March 4, 2005.

Attached for your reference is a revised "fact sheet" and a proposed amendment to clarify the language on page 1, lines 25-30 Section (3). The original language for the bill was a contribution from Blue Cross/Blue Shield and I believe the final language was arrived at during the final drafting.

The language we've attached has been sent to Legislative Counsel for drafting purposes. I hope this is more concise and clear. For your reference, I've also included the original Blue Cross/Blue Shield language so you can see where we started. I hope this proposed change is what the Committee is looking for.

Please don't hesitate to contact Jennifer Massman (5223) or me (2004) if you have further questions. We will also be available to the committee if you have questions while you are in executive session.

Thank you.

Alicia Pichette

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HB 156
An Act Establishing Reciprocal time limits for Health Insurance Claim Filing

Senate Business, Labor, and Economic Affairs Committee Questions and State Auditor's Office Responses

Is HB 156 based on a model act?

No. The NAIC has not developed a model act regarding how long health insurance issuers may wait to request reimbursement of invalid or overpaid claims. However, several states have laws limiting how long health insurance issuers may wait before seeking reimbursement of invalid or overpaid claims.

Do other states have laws similar to HB 156?

Yes. At least 8 other states [Arizona, Missouri, Alabama, Louisiana, Maryland, Kentucky, Oklahoma, and Virginia] have similar laws regarding how long health insurance issuers have to audit claim payments and request reimbursement of invalid or overpaid claims. Virginia and Louisiana have reciprocity requirements and the other states have specific time limits. The laws of each of these states were reviewed in drafting HB 156, however, none of these state laws were used verbatim.

Does HB 156 apply only to a health insurance issuers' relationship with participating providers?

No. HB 156 would apply to claims submitted to a health insurance issuer by any provider or insured.

Does HB 156 apply to workers' compensation insurance?

No. Section 3 provides that HB 156 does not apply to workers' compensation insurance.

What is the process of insurance payment of medical services?

After an insured patient receives medical services, the medical service provider files a claim for payment with that patient's health insurance issuer. Based on the insurance contract, the insurer determines which services will be covered and the amount of reimbursement. The payment is then remitted to the insured patient or directly to the medical service provider. An explanation of benefits is sent to the insured patient. If the insured patient disagrees with the amount covered, he may request a review by the insurer. After the insurer completes its review, the insurer advises the insured patient whether or not it will pay any more on the disputed amount covered. If the insured patient still disagrees, he may file suit to obtain a court judgment on which services are covered and the proper amount of reimbursement.

In New West's proposed amendment, what does "prejudice" mean?

As used in the proposed amendment, "prejudice" means adversely affected or harmed.

Why does the State Auditor's Office oppose New West's amendment?

The State Auditor's Office opposes the amendment because HB 156 is a consumer protection bill that limits health insurance issuers' ability to audit and request reimbursement of claims paid years earlier. The amendment proposed by New West would allow health insurance issuers to deny all late filed claims and if the insured sued for his coverage, the health insurance issuer would not need to show how it had been adversely affected or harmed by the late filed claim.

When a claim is filed late, the insurer is in the best position to assess whether it was prejudiced or harmed by the delay and then produce the evidence to demonstrate that it was prejudiced. Otherwise, the consumer would have to prove a "negative fact" that the insurer was not prejudiced by the late claim filing. Further, if no clear proof of prejudice is available, placing the burden of proof on the insurer protects the consumer from losing coverage.

The proposed amendment will harm consumers because it allows insurers to automatically deny any claims filed even one day late regardless of the reason.

PROPOSED AMENDMENT
HB 156
Introduced by _____
Prepared by the State Auditor
3/7/05

Proposed Amendment to Section 1 of HB 156:

1. Page 1, lines 25 through 30
   Following: "(3)"
   Strike: "(a)" on line 25 through "payment." on line 30
   Insert: "Regardless of the period of time allowed by a health insurance issuer for submission of claims for payment, a health insurance issuer may perform a review or audit to reconsider the validity of a claim and may request reimbursement for an invalid or overpaid claim within 12 months from the date upon which the health insurance issuer received notice of a determination, adjustment, or agreement regarding the amount payable with respect to such a claim by:"

2. Page 2, lines 1 through 2
   Strike: "(b)" on line 1 through "by:"on line 2

3. Page 2, lines 3 through 9
   Strike: "(i)" on line 3
   Insert: "(a)"
   Renumber: subsequent subsections

-END-

Attachment B
Suggested changes to DOI Reimbursement for Overpayment Bill
Prepared by Greg Gould, 495-3316, ggould@bcbsmt.com
11/19/2004 11:02 AM
Bill Draft Version Printed 8/24/2004

Bill Title, page 1, line 4, revise "except in cases of insurance fraud" to read: "except in cases of insurance fraud and other enumerated circumstances"

Section 1, page 2, line 2
Following: "except"
Insert: "as provided in (2) or"

Section 1, page 2, line 3
Following: "because of"
Insert: "an error, misrepresentation, omission, concealment or"

Section 1, p. 2, line 7
Following: subsection (1)
Insert: "(2) A health insurance issuer may perform any review or audit for purposes of reconsidering the validity of such claims and may request reimbursement for payment of invalid claims or for overpayment of any claims within one year from the date upon which the health insurance issuer receives notice of a determination, adjustment or agreement, regardless of the period of time allowed by the health insurance issuer for submission of claims for payment, where the final determination of the amount payable by the health insurance issuer on any claim depends upon a determination, adjustment or agreement regarding the amount payable with respect to the claim by:

(a) medicare;

(b) a workers' compensation carrier or insurer;

(c) another health insurance issuer or group health plan;

(d) a liable or potentially liable third party, including determination, adjustment or agreement regarding an amount payable pursuant to a right of subrogation; or

(e) a foreign health insurance issuer, under an agreement among plans operating in different states providing for payment by the Montana health insurance issuer, as host plan, of Montana providers for services provided to an individual under a plan issued outside the state of Montana.

[Renumber subsequent subsections.]

Section 1, page 2, line 20
Following: "except"
Insert: "as provided in (2) or"

Section 1, page 2, line 21
Following: "because of"

Insert: "an error, misrepresentation, omission, concealment or".

Page 4, following section 4
Insert:

NEW SECTION. Section 5. Applicability date. [This act] applies to claims paid by a health insurance issuer on or after January 1, 2006.

Question: Under Section 3, as amended by this proposal, would new section 1 apply to group and blanket policies? As I read the language, section 1 would so apply.