SENATE BILL No. 253

By Committee on Ways and Means

5-24

AN ACT concerning insurance; pertaining to health benefit plans and dental plans; establishing the prompt payment act; amending K.S.A. 2016 Supp. 40-2,103 and 40-19c09 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) The provisions of sections 1 through 8, and amendments thereto shall be known and may be cited as the prompt payment act.

(b) The provisions of the prompt payment act shall apply to any health benefit plan, health insurer, non-profit dental service corporation and dental plan organization that provides coverage for accident, health or dental services and that is delivered, issued for delivery, amended or renewed in the state of Kansas, and to any third-party administrator, employee or other representative that processes claims thereof.

New Sec. 2. As used in this act:

(a) "Administrator" or "third-party administrator" means any entity, including the subsidiary of a carrier or an organized delivery system with which a carrier has contracted to perform claims processing or claims payment services.

(b) "ADR" means alternative dispute resolution.

(c) "Capitation payment" means a periodic payment to a healthcare provider for services under the terms of a contract between the provider and a carrier, under which the provider agrees to perform the healthcare services set forth in the contract for a specified period of time for a specified fee, but shall not include any payments made to the provider on a fee-for-service basis.

(d) "Carrier" means an insurance company, health benefit plan, health insurer, non-profit dental service corporation or dental plan organization that provides coverage for accident, health or dental services in the state of Kansas.

(e) "Commissioner" means the state commissioner of insurance.

(f) "Claim" means a request by a covered person, a participating healthcare provider, or a nonparticipating healthcare provider who has received an assignment of benefits from the covered person, for payment relating to healthcare services or supplies or dental services or supplies covered under a health benefits plan or dental plan issued by a carrier.

(g) "Clean claim" means:
(1) The claim is for a service or supply covered by the health benefits plan or dental plan;
(2) the claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;
(3) the person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;
(4) the carrier does not reasonably believe that the claim has been submitted fraudulently; and
(5) the claim does not require special treatment. For the purposes of this act, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.
(h) "Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits or dental plan.
(i) "Covered service or supply" means a service or supply provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or that provides services or supplies.
(j) "Dental plan" means a benefits plan that pays dental expense benefits or provides dental services and supplies and is delivered or issued for delivery in this state by or through any carrier in this state.
(k) "Department" means the Kansas insurance department.
(l) "Health benefit plan" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.
(m) "Health insurer" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.
(n) "Healthcare services" shall have the meaning ascribed to it in K.S.A. 40-3202, and amendments thereto.
(o) "Organized delivery system" or "system" means an organization with defined governance that:
(1) Is organized for the purpose of and has the capability of contracting with a carrier to provide, or arrange to provide, under its own management, substantially all or a substantial portion of the comprehensive healthcare services or benefits under the carrier's benefits plan on behalf of the carrier, which may or may not include the payment of hospital and ancillary benefits; or
(2) is organized for the purpose of acting on behalf of a carrier to provide, or arrange to provide, limited healthcare services that the carrier

elects to subcontract for as a separate category of benefits and services apart from its delivery of benefits under its comprehensive benefits plan, which limited services are provided on a separate contractual basis and under different terms and conditions than those governing the delivery of benefits and services under the carrier's comprehensive benefits plan.

An organized delivery system shall not include an entity otherwise authorized or licensed in this state to provide comprehensive or limited healthcare services on a prepayment or other basis in connection with a health benefits plan or a carrier.

(p) "Provider" or "healthcare provider" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto. "Provider" or "healthcare provider" shall also include any dentist licensed by the Kansas dental board.

New Sec. 3. (a) A carrier or its administrator shall acknowledge receipt of all claims. The acknowledgement shall include the date the carrier or its administrator received the claim.

(1) If a claim is submitted by electronic means, the claim shall be acknowledged electronically no later than two working days following receipt of the claim. The acknowledgement of receipt of an electronic claim shall go to the entity from which the carrier received the claim.

(2) If a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim.

(b) If a carrier or its administrator remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment shall constitute acknowledgement of receipt.

(c) If a carrier offers providers web-based access to claims status, the available information shall include the date of receipt of the claims. Such information, if posted within the timelines established in subsection (a)(2), shall constitute acknowledgement of receipt of those claims.

(d) If a carrier offers providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in subsection (a)(2), the posting of that information shall constitute acknowledgement of receipt of those claims.

New Sec. 4. A carrier or its administrator shall notify its participating healthcare providers at least annually, and shall make available to covered persons on request, a listing of the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the carrier for both manually and electronically submitted claims. Carriers or their

administrators may change the required information and documentation as long as participating healthcare providers are given at least 30 days' prior notice of the change in the requirements. Carriers or their administrators shall also supply participating healthcare providers with a street address where claim submissions can be delivered by hand or registered or certified mail.

New Sec. 5. (a) A carrier and its administrator shall remit payment of clean claims pursuant to the following time frames:

(1) Thirty calendar days after receipt of the claim where the claim is submitted by electronic means or the time established for the federal medicare program by 42 U.S.C. § 1395u(c)(2)(B), whichever is earlier; or

(2) forty calendar days after receipt of the claim where the claim is submitted by other than electronic means.

(b) Carriers and their administrators shall pay claims that are disputed or denied because of missing information or documentation within 30 or 40 calendar days of receipt of the missing information or documentation, as applicable, pursuant to subsection (a).

(c) Payment of a claim shall be considered to have been made:

(1) On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or

(2) if not paid pursuant to subsection (c)(1), on the date of delivery of a draft or other valid instrument equivalent to payment.

(d) A carrier or its administrator shall maintain an auditable record of when payments were transmitted to healthcare providers or covered persons, whether by United States mail or otherwise.

New Sec. 6. (a) A carrier or its administrator shall either deny or dispute a claim, in full or in part, that has not been processed according to section 5, and amendments thereto. If only a portion of a claim is disputed or denied, the carrier or its administrator shall remit payment for the uncontested portion in accordance with section 5, and amendments thereto. The pending of a claim does not constitute a dispute or denial. The carrier or its administrator shall, within 30 or 40 calendar days of receipt of the claim, whichever is applicable, notify both the covered person when the person will have increased responsibility for payment and the provider of the basis for its decision to deny or dispute, including:

(1) The identification and explanation of all reasons why the claim was denied or disputed.

(A) If a claim is denied because it cannot be entered into the claims system, then all reasons why the claim cannot be entered into the claims systems shall be included.

(i) Examples of reasons why a claim cannot be entered into the claims system include: The group is not covered on the date of service; the

1 employee or dependent is not covered on the date of service; non-payment
2 of premium; missing data fields; missing or incorrect data, for example,
3 CPT code, date of service, or provider name; or ineligible provider.
4 (ii) If the reasons why a claim cannot be entered into the claims
5 system are subsequently cured and the claim is entered, the carrier's first
6 review after the claim is entered shall identify all applicable reasons for
7 any denial or disputed claim.
8 (B) A carrier or its administrator shall not deny or dispute a claim for
9 reasons other than those identified in the first review after the claim is
10 entered, unless information or documentation relevant to the claim is
11 received after the first review and such documentation leads to additional
12 reasons to deny or dispute, which were not present at the time of that
13 review.
14 (2) Where missing information or documentation is a reason for
15 denying or disputing a claim, the notice shall identify with specificity the
16 additional information or documentation that is required and the carrier
17 shall engage in a good faith effort to expeditiously obtain such additional
18 information or document by, among other things, telephoning the provider.
19 (3) If the amount of the claim is disputed, an explanation of the
20 reason for the dispute, including any change of coding performed by the
21 carrier and the reasons for such change of coding.
22 (4) The toll-free telephone number for the carrier or its administrator
23 who can be contacted by the provider or covered person to discuss the
24 claim.
25 (b) A carrier or its administrator that does not provide the notice
26 required by subsection (a) shall waive its right to contest the claim for any
27 reason other than the referral of the claim to the criminal anti-fraud
28 division of the department.
29 (c) If the carrier or its administrator fails to pay a clean claim within
30 the time limits set forth in section 5, and amendments thereto, the carrier
31 shall include simple interest on the claim amount at the rate of 10% per
32 year and shall either add the interest amount to the claim amount when
33 paying the claim, or issue an interest payment within 14 days of the
34 payment of the claim. Interest shall accrue beginning 30 or 40 days, as
35 applicable, from the date all information and documentation required to
36 process the claim is received by the carrier. The carrier may aggregate
37 interest amounts up to $25, with the consent of the provider.
38 (d) If a carrier has reason to believe that the claim has been submitted
39 fraudulently, it shall investigate the claim in accordance with its own fraud
40 prevention or, if applicable, refer the claim to the criminal anti-fraud
41 division of the department.
42 (e) Unless otherwise provided by law, every carrier or its
43 administrator shall pay the amount finally agreed upon in settlement of all

or part of any claim not later than ten working days from either the receipt of such agreement by the carrier or the date of the performance by the covered person or the provider of any conditions to payment set forth in the agreement, whichever is later.

(f) Carrier adjustments to claims previously paid shall be based only on actual identifiable errors in the submission, processing or payment of a particular claim or claims, and shall not be based on extrapolation, with the following exceptions:

(1) Where the extrapolation, including the method, is non-binding;

(2) in judicial or quasi-judicial proceedings, including arbitration;

(3) in governmental administrative proceedings;

(4) where relevant records required to be maintained by the provider have been improperly altered or reconstructed, or a material number of such records are unavailable; or

(5) where there is clear evidence of claim fraud or abuse by the provider.

New Sec. 7. (a) Payment of a capitation payment to a healthcare provider shall be deemed to be overdue if not remitted to the provider on the fifth business day following the due date of the payment in the contract, if:

(1) The healthcare provider is not in violation of the terms of the contract; and

(2) the healthcare provider has supplied such information to the insurer as may be required under the contract before payment is to be made.

(b) An overdue payment shall include simple interest on the amount of the payment at the rate of 10% per year and shall add the interest amount to the payment when it is made.

New Sec. 8. (a) Every carrier shall establish an internal appeals mechanism to resolve disputes between carriers or their administrators and participating healthcare providers relating to payment of claims. The internal appeals mechanism shall be described in the participating provider contract.

(1) The internal review shall be conducted by employees of the carrier who shall be personnel other than those responsible for claims payment on a day-to-day basis and shall be provided at no cost to the provider.

(2) The internal review shall be conducted and its results communicated in a written decision to the provider within 10 business days of the receipt of the appeal. The written decision shall include:

(A) The names, titles and qualifying credentials of the persons participating in the internal review;

(B) a statement of the participating provider's grievance;

(C) the decision of the reviewers along with a detailed explanation of the contractual or medical basis, or both for such decision;

(D) a description of the evidence or documentation that supports the decision; and

(E) if the decision is adverse, a description of the method to obtain an external review of the decision.

(b) Every carrier shall offer an independent, external ADR mechanism to participating healthcare providers to review adverse decisions of its internal appeals process.

(1) The ADR mechanism shall be through an independent party. The costs of the process shall be borne equally by the parties. The recommended decision of the ADR mechanism shall be issued no later than 30 business days from receipt by the ADR firm of all documentation necessary to complete the review.

(2) The ADR mechanism, including the method to submit a claim through such mechanism, shall be described in the participating provider contract and in the final internal decision denying or disputing the participating healthcare provider's claim, in full or in part.

(3) The decision of the ADR mechanism shall be nonbinding, unless the parties agree otherwise.

(c) Carriers shall annually notify participating providers in writing of the internal appeals process and the ADR mechanism and how they can be utilized.

(d) Carriers shall annually report, in a format prescribed by the department, which includes the number of internal and external provider appeals received and how they were resolved.

Sec. 9. K.S.A. 2016 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114, 40-2,160, 40-2,165 through 40-2,170, ~~inclusive,~~ *and* 40-2250, K.S.A. 2016 Supp. 40-2,105a, 40-2,105b, 40-2,184, 40-2,190 and 40-2,194*, and sections 1 through 8*, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 10. K.S.A. 2016 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 ~~to~~ *through* 74~~, inclusive,~~ of chapter 17 of the Kansas Statutes Annotated, and amendments thereto, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250,

40-251, 40-252, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2,125, 40-2,153, 40-2,154, 40-2,160, 40-2,161, 40-2,163 through 40-2,170~~, inclusive,~~ 40-2a01 et seq., 40-2111~~ to~~ *through* 40-2116~~, inclusive,~~ 40-2215~~ to~~ *through* 40-2220~~, inclusive,~~ 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401~~ to~~ *through* 40-2421~~, inclusive,~~ and 40-3301~~ to~~ *through* 40-3313, ~~inclusive,~~ K.S.A. 2016 Supp. 40-2,105a, 40-2,105b, 40-2,184, 40-2,190 and 40-2,194*, and sections 1 through 8*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

(b) No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 11. K.S.A. 2016 Supp. 40-2,103 and 40-19c09 are hereby repealed.

Sec. 12. This act shall take effect and be in force from and after January 1, 2018, and its publication in the statute book.