

SENATE BILL No. 253

By Committee on Ways and Means

5-24

1 AN ACT concerning insurance; pertaining to health benefit plans and
2 dental plans; establishing the prompt payment act; amending K.S.A.
3 2016 Supp. 40-2,103 and 40-19c09 and repealing the existing sections.
4

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

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

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

15 New Sec. 2. As used in this act:

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

20 (b) "ADR" means alternative dispute resolution.

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

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

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

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

1 (g) "Clean claim" means:

2 (1) The claim is for a service or supply covered by the health benefits
3 plan or dental plan;

4 (2) the claim is submitted with all the information requested by the
5 carrier on the claim form or in other instructions distributed to the provider
6 or covered person;

7 (3) the person to whom the service or supply was provided was
8 covered by the carrier's health benefits or dental plan on the date of
9 service;

10 (4) the carrier does not reasonably believe that the claim has been
11 submitted fraudulently; and

12 (5) the claim does not require special treatment. For the purposes of
13 this act, special treatment means that unusual claim processing is required
14 to determine whether a service or supply is covered, such as claims
15 involving experimental treatments or newly approved medications. The
16 circumstances requiring special treatment should be documented in the
17 claim file.

18 (h) "Covered person" means a person on whose behalf a carrier
19 offering the plan is obligated to pay benefits or provide services pursuant
20 to the health benefits or dental plan.

21 (i) "Covered service or supply" means a service or supply provided to
22 a covered person under a health benefits or dental plan for which the
23 carrier is obligated to pay benefits or that provides services or supplies.

24 (j) "Dental plan" means a benefits plan that pays dental expense
25 benefits or provides dental services and supplies and is delivered or issued
26 for delivery in this state by or through any carrier in this state.

27 (k) "Department" means the Kansas insurance department.

28 (l) "Health benefit plan" shall have the meaning ascribed to it in
29 K.S.A. 40-4602, and amendments thereto.

30 (m) "Health insurer" shall have the meaning ascribed to it in K.S.A.
31 40-4602, and amendments thereto.

32 (n) "Healthcare services" shall have the meaning ascribed to it in
33 K.S.A. 40-3202, and amendments thereto.

34 (o) "Organized delivery system" or "system" means an organization
35 with defined governance that:

36 (1) Is organized for the purpose of and has the capability of
37 contracting with a carrier to provide, or arrange to provide, under its own
38 management, substantially all or a substantial portion of the
39 comprehensive healthcare services or benefits under the carrier's benefits
40 plan on behalf of the carrier, which may or may not include the payment of
41 hospital and ancillary benefits; or

42 (2) is organized for the purpose of acting on behalf of a carrier to
43 provide, or arrange to provide, limited healthcare services that the carrier

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (b) Carriers and their administrators shall pay claims that are disputed
15 or denied because of missing information or documentation within 30 or
16 40 calendar days of receipt of the missing information or documentation,
17 as applicable, pursuant to subsection (a).

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

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

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

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

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

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

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

42 (i) Examples of reasons why a claim cannot be entered into the claims
43 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

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

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

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

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

11 (3) in governmental administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 Sec. 9. K.S.A. 2016 Supp. 40-2,103 is hereby amended to read as
28 follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-
29 2,102, 40-2,104, 40-2,105, 40-2,114, 40-2,160, 40-2,165 through 40-2,170,
30 ~~inclusive~~, and 40-2250, K.S.A. 2016 Supp. 40-2,105a, 40-2,105b, 40-
31 2,184, 40-2,190 and 40-2,194, and sections 1 through 8, and amendments
32 thereto, shall apply to all insurance policies, subscriber contracts or
33 certificates of insurance delivered, renewed or issued for delivery within or
34 outside of this state or used within this state by or for an individual who
35 resides or is employed in this state.

36 Sec. 10. K.S.A. 2016 Supp. 40-19c09 is hereby amended to read as
37 follows: 40-19c09. (a) Corporations organized under the nonprofit medical
38 and hospital service corporation act shall be subject to the provisions of
39 the Kansas general corporation code, articles ~~60 to through 74, inclusive,~~
40 of chapter 17 of the Kansas Statutes Annotated, and amendments thereto,
41 applicable to nonprofit corporations, to the provisions of K.S.A. 40-214,
42 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-229,
43 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250,

1 40-251, 40-252, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-
2 2,105, 40-2,116, 40-2,117, 40-2,125, 40-2,153, 40-2,154, 40-2,160, 40-
3 2,161, 40-2,163 through 40-2,170, ~~inclusive~~, 40-2a01 et seq., 40-2111 ~~to~~
4 ~~through~~ 40-2116, ~~inclusive~~, 40-2215 ~~to through~~ 40-2220, ~~inclusive~~, 40-
5 2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254,
6 40-2401 ~~to through~~ 40-2421, ~~inclusive~~, and 40-3301 ~~to through~~ 40-3313,
7 ~~inclusive~~; K.S.A. 2016 Supp. 40-2,105a, 40-2,105b, 40-2,184, 40-2,190
8 and 40-2,194, *and sections 1 through 8*, and amendments thereto, except
9 as the context otherwise requires, and shall not be subject to any other
10 provisions of the insurance code except as expressly provided in this act.

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

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

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

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