Kansas Association of Health Plans

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HB 2565
Testimony before the House Insurance Committee
Marlee Carpenter, Executive Director

Chairman Shultz and members of the Committee;

I am Marlee Carpenter, Executive Director of the Kansas Association of Health Plans (KAHP). The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comments to this committee.

KAHP is here today to express concerns about HB 2565. This bill is problematic for insurers and self-funded health plans. HB 2565 requires the health insurance issuer to provide an accurate and binding statement of covered services and the costs for those services. The binding statement must identify:

1. The amount the patient will be expected to pay including their deductible, coinsurance, and copay;
2. The provider's payment for services from the health insurance issuer;
3. Services for which coverage will be denied;
4. Information on payments that will be reduced from an agreed upon fee schedule; and,
5. Information on if and why any of the health care services will be bundled with other services.

Health insurance issuers are able to provide members and their providers with an estimate of health care service cost today via our customer service representatives or website portal. However, these estimates are based on the information that is available at that time. A provider and their patient may not be aware of all possible services that will occur during a procedure. The types of health care services and procedures that are performed by a provider are not always certain prior to a patient's scheduled health

House Insurance
Date: 2-15-12
Attachment # 12

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care service. This could lead to a patient and provider relying on a statement of cost and payment that are inappropriate based on the services that were performed.

Also, a patient may have outstanding claims that will impact their deductible and coinsurance responsibilities. The provider, patient, and health insurance issuer may not be aware of these outstanding claims. The health insurance issuer will not be able to provide an accurate deductible and coinsurance amount for that member until all outstanding claims are received and processed.

In addition, there is no HIPAA transaction standard that would allow for a health insurer to predetermine the cost of a service for a provider. Standards have been developed for Dental insurance transactions, but a similar standard has not been developed, vetted, and approved for use nationally.

The current HIPAA transaction code, 837P, is used as the electronic claims format for professional providers and institutions (e.g, doctors and hospitals), but it does not allow the provider or insurer to acknowledge whether the electronic claim is based on a pre-determined price. National committees have discussed developing a HIPAA transaction standard that would allow for pricing pre-determinations, but a standard takes years to adopt. Based on the activities of these committees, a pricing pre-determination standard will not be developed by 2014.

Finally, KAHP members believe that HB 2565 constitutes a new mandate on insurance companies, requiring them to use a certain type technology to predetermine claims information that is not yet developed nor is HIPAA compliant.

Thank you for your time and I will be happy to answer questions at any time.