Approved: April 7, 2000
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE

The meeting was called to order by Chairperson Rep. Robert Tomlinson at 3:35 p. m. on March 21, 2000 in Room 519-S of the Capitol.

All members were present except: Representative Vining
Representative Empson
Representative O'Brien

Committee staff present: Dr. Bill Wolff, Research
Ken Wilke, Revisor
Mary Best, Secretary

Conferees appearing before the committee: Linda DeCoursey, Kansas Insurance Department
Jerry Slaughter, Kansas Medical Mutual Insurance Company
Jim Sergeant, Kansas Hospital Association and
Wesley Medical Center
Paul Wardlow, M.D., Olathe Medical Services, Inc.
Jeff Eckart, Mid-America Cardiologists Associates, P. C.
Jean Garten, Olathe Medical Center
Larry Ann Lower, Kansas Association of Health Plans
Brad Smoot, Blue Cross/Blue Shield of Kansas/Kansas City

Others attending: See attached Committee Guest List

Following the committee announcements the Chairman brought the committee's attention to **HB 3022-Prompt payment of insurance claims and SB 600-Insurance; prompt payment requirements for insurance companies.** The two bills were being heard together since they were of basically had the same subject matter.

Ms. Linda DeCoursey, Director of Government Affairs, Kansas Insurance Department, was the first conferee to address the bills. Ms. DeCoursey offered Proponent Testimony on both bills. A copy of both bills are (Attachment #1)attached hereto and incorporated into the Minutes by reference. Ms. DeCoursey gave an overview of the two bills and explained their differences and their similarities, with **HB 3022** being the same bill as **SB 600** and **Sub for SB 600** including many of the provisions set out in **SB 575.**

The above two aforementioned bills address the problem brought forth by the health care providers regarding their collection of payment from the insurance providers. It was stated that some health insurers take up to 120 days to pay their claims. Some of the providers have told the Insurance Department that they have had to take out loans to keep their businesses afloat due to the delay in payment. This, it was stated can but a practice at risk.

This is not confined solely to Kansas, but is a nation wide problem. Ms. DeCoursey informed the committee, "A may 9, 1999 article from the New York Times revealed that, on average, hospitals in the United States receive payment from the health insurers over 60-days after submitting a claim and that average includes the good, efficient insurers that pay claims promptly."

Ms. DeCoursey informed the committee that at least twenty-one states have passed laws requiring insurers to promptly pay their claims, which targeted time-line is approximately 30-60 days and offer penalties and interest payments to other sanctions if the time-line is not met.

It was noted that many hours, research, discussion and finally agreed upon compromises by ally parties involved to reach what is known as **Sub. For SB 600**.

The Insurance Department found in their research, similarities throughout other states kept reappearing. Among these were: Definition section set out scope of clean claim and not clean claim; Time tables to file and pay claims as well as requests for additional information; Penalties in the form of interest were being used throughout these same states. Penalties ran from 18% per annum to 9% and with other states using prime, T-bill or their state legal rate.

Ms. DeCoursey continued on to explain **Sub For SB 600** the results of the compromise committee's work. This bill defines "Clean Claim"; "Claim" as per K.S.A. 40-2203 (A)(7); Time line of requirement to pay "clean claim"; Requirements of health insurers to providers regarding status of claim and any pertinent information pertaining to the payment of the claim; Interest requirements to be paid on unpaid balances after a stated time period; Expectations on the part of the provider to furnish all and any information to the insurer and the time expected to do this; Requirement to the insurer do pay within the time period or give notice with in specified time line as to why not paid; Explicitly links this law to the unfair Trade Practices Act; "Allows for a good faith dispute faith about legitimacy of the claim when reasonable basis that claim was submitted fraudulently."; "Allows for the commissioner to adopt rules and regulations necessary to carry out the act.."; and "Allows a delay in the enforcement date to: January 1, 2001."

Ms. DeCoursey then gave a summation of her testimony and asked the committee to remember that many and most of our prominent insurers do now pay the claims promptly. With this she stood for questions.

Questions were received from: Representatives Boston, Myers. The questions addressed the time element, and the percentage for the fine. The House and Senate form of the bill was briefly discussed.

The second conferee on the bill was Mr. Jerry Slaughter, Executive Director, Kansas Medical Mutual Society. A copy of the written Proponent Testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference. Mr. Slaughter educated the committee on the problem his clients have been faced with when the payments for providers are late or delayed. Mr. Slaughter informed the committee the cash flow in their perspective clinics cause what they feel are unnecessary administrative costs and unnecessary time calling the carrier regarding the claim. He times the providers end up submitting additional information to the insurer before they will or can pay the claim.

He continued on to state that the problem is confined to a few carriers and third party administrators, for now. Mr. Slaughter feels that this legislation is needed before the circumstances get worse and the number of carriers delays grows. They feel that both insurer and provider will benefit from this legislation as it will specifically state the rules and the fines imposed. They feel a uniform law defining "clean claim", or a claim that is ready to be paid, will go a long way to improving the situation. In turn these same uniform laws will instruct the providers to make an all out effort to file their claims in a timely manner, in an appropriate manner and will all necessary information.

After summarizing his testimony and informing the committee that his organization was involved in the talks on the compromise, Mr. Slaughter stood for questions from the committee.

Questions were posed by Chairman Tomlinson regarding the comfort level they had within the compromise. They also discussed the time element and percentage rate for penalties. Mr. Slaughter stated they preferred 30 days but could live with 45. Other questions were posed by Representatives Kirk, and McCreary.

Mr. Jim Sargeant, Vice President of Managed Care on behalf of Wesley Medical Center, was the next conferee to be recognized before the committee. Mr. Sargeant gave Proponent Testimony. A Copy of the testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference. Mr. Sargeant stated that across the country,, hospitals and various other providers were experiencing delays from insurers cutting the payments to the providers. Mr. Sargeant stated that cash flow was a significant issue among the providers and any delays threatened access to health care services if cash flows were insufficient to cover operating costs. Mr. Sargeant continued on to state, "At the national level, hospital claims languished in accounts receivable an average of 67.1 days in 1998-an increase of 2.6 days from 1995." These figures again changed from 71 in 1996 to 75 in 1998. Wesley Medical Center has experienced 65 days for 1999. He continues by saying that these figures represented "a loss of interest earnings due to balance exceeding 45

days of $132, 722. Each additional day represents money that is owed to Kansas hospitals, but is unavailable to them to pay staff, bills or interest on debts."

Mr. Sargeant, spoke of and acknowledged the hard work that went into the bill and acknowledged that many of the trouble companies were not a part of the meetings and were not coming forward to assist in eliminating the problems. He did however, wish to thank all those who did come forward to the table and continued on by stating, ".......we all came to agreement on some balloon amendments to the prompt pay bill." Mr. Sargent then covered the interest figures as well as the time factors.. Mr. Sargeant feels "adopting the amendments will make the bill stronger, but they are willing to live with he bill as presented to the Senate FII with the Agreed amendments."

Mr. Sargeant feels there will be a need for monitoring and continued cooperation on the part of the health plans providers and Insurance Commissioner, but that **Sub For SB 600** was a good place to start. With this Mr. Sargeant stood for questions.

Questions were presented by Chairman Tomlinson who questioned Mr. Sargeant regarding the original compromise. Mr. Sargeant declined saying he was not interested.

Paul Wardlow, M.D, Physician Director, Olathe Medical Services, Inc., was the next conferee to present Proponent Testimony to the committee. Dr. Wardlow's testimony is (Attachment #4) attached hereto and incorporated into the Minutes by reference. Dr. Wardlow's testimony echoed much of the previous testimony stating how the insurers need not take so much time to pay claims and the penalties that should apply. Dr. Wardlow stated the insurers should at least pay the undisputed portion of the bill in a timely manner while they research or wait on information to process the disputed part of the claim. Dr. Wardlow asked the committee not to create loopholes and to hold insurers to these standards. Dr. Wardlow stood for questions. There were none.

Mr. Gary Stanton, Medical Clinic Manager, Overland Park, Kansas, was the next scheduled conferee to speak to the bill. Mr. Stanton instead presented written testimony and deferred his oral presentation to a female colleague (name unknown). A copy of Mr. Stanton's written testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference. Ms. "Doe"stated much of what the other conferees had already presented to the committee. And stating the first 12 points of Mr. Stanton's testimony covered prompt payment. They felt Kansas Blue Cross posed no problem and usually received payment within less than 3 weeks. They also pointed out Medicare usually pays within 14 days. United Health Care and Principals within 10-13 days. As a rule Ms. "Doe" stated, the norm is 30 days and this standard should be met and kept by all. She felt the 1-1and 1/2% is no big issue by the insurers need to be held to pay promptly They felt the insurers should pay the undisputed portion upon receipt of the billing and not blindly deny everything. She also stated that the electronic billing can become backed up and that the networks should be held accountable for these delays.

Questions were asked by: Representatives Boston, McCreary, Phelps, and the Chairman. Some of the responses were deferred to Mr. Jerry Slaughter by Ms. "Doe". Questions ranged from defining "clean claim" who says when interest rates and fines start; who are the bill submitted directly to; any indication of number of backlogged billings or do the networks keep these records; to are Medicare claims paid 100% and why the number of days are so hard to reach an agreement or compromise on.

The next conferee to come before the committee was Mr. Jeff Eckart, Mid-America Cardiology Associates, P.C. A copy of Mr. Eckart's testimony is (Attachment #6) attached hereto and incorporated into the Minutes by reference. Mr. Eckart supported previous testimony supporting the bill. He continued by stating that many of these clinics and providers have to take out loans in order to pay the bills and administrative costs. Mr. Eckart informed the committee that they had bills over 120 days old and were on a credit watch as they were not always able to pay what they owed to their creditors. He continued on to relate to the committee that his organization is one of the larger groups in Kansas City, Missouri.

Mr. Eckart informed the committee that he did not feel that interest penalties alone would work to correct the problem. He said Missouri had enacted prompt pay legislation and the situation only worsened. He stated

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

that with the insurer it was "business as usual." Mr. Eckart feels that insurers "make their own rules and follow them arbitrarily." Instead he feels rules much like HCFA/Medicare should be used and if so then a prompt pay bill would not be necessary. Mr. Eckart also felt the providers "must have prompt pay recourse for payment." He stated that if the insurer did not pay the bill within a timely manner than the provider should be able to bill the patient directly." Finally, Mr. Eckart felt "In order to have the ability to enter into healthcare contracts as an informed provider, payors should be required to fully disclose complete fee schedules, patient demographic data, lists of contracted area facilities, and policy and procedure manuals, before contracts are signed."

Mr. Eckart closed with informing the committee that it is time to force payors to meet their obligations and that if legislation is not brought forth to correct the issue that Kansas will see practices closing, the better doctors retiring or leaving and going elsewhere for higher paying jobs and to set up practice. With this Mr. Ekart stood for questions.

Questions were asked by Representative Burroughs and Chairman Tomlinson. Questions asked addressed civil remedies with the patient borrowing money, hiring attorneys (more money), does this not harm the patient and their credit history; to organizations stacking bills higher than the original contract; of 4000 payers, 100 contracts what percentage of back payments are there? Response, approximately 10%.

With no further discussion, the Chairman recognized Ms. Jean Garten, Director Managed Care, Olathe Medical Center, Olathe, Kansas. Ms. Garten offered written testimony in support of the bill. A copy of the bill is (Attachment #7) attached hereto and incorporated into the Minutes by reference.

Ms. Garten informed the committee that she had not seen any of the latest amendments and could only therefore offer her written testimony and declare the problems her organization had experience which was much the same as the previous conferees. There were no questions.

Ms. Larry Ann Lower, Kansas Association of Health Plans, was the next conferee to be recognized by the Chairman. Ms. Lower offered Proponent Testimony to the committee and a copy of the testimony is (Attachment #8) attached hereto and incorporated into the Minutes by reference. Ms. Lower stated that she was also carrying an amendment to the bill. A copy of the amendment is (Attachment #9) attached hereto and incorporated into the Minutes by reference. The amendment bore the changes regarding time on page 1, line 41 and line 12, page 2, change from 30 days to 45 days and page 2, lines11 and 33 change percentages from 1.5% to1.0%.

Ms. Lower informed the committee that there were several months of work, meetings and compromises put into the bill its' amendment. Sitting at the meetings were Kansas Insurance Department, Kansas Medical Society, Kansas Hospital Association, the Health Insurance Association of America and Kansas Association of Health Plans. They all reached an agreeable compromise on the prompt pay bill. It was then added to **SB 600**. Ms. Lower stated a thorough discussion of current law at al levels was held. Compromises were made and testimony to oppose was dropped, hence the Senate Committee benefitted nothing from the traditional debate, which is normally part of the hearing process. She also informed the committee that sorry to say the amendments adopted last week by the Senate and passed by the full Senate lacked all of the facts or understanding of the law pertaining to this matter.

Ms. Lower and her clients are urging the committee to adopt the original compromise language that is set out in their amendment. She continued on to relate that federal law uses a 30-day rule and health plans dealing with Medicaid Supplements must pay 95% of their claims within 30 days. According to the bill before the committee now, there is no requirement to pay all claims within the standards amended into **SB 600.**

Ms. Lower continued on to relate to the committee that there is only one Medicare payer in Kansas which is BCBSKS. There are only six Medicare HMO's and a few hundred approved health insurers sell Medicare Supplements. This means that even if Medicaid standards were imposed on carriers there would be substantial changes for a good many of these same insurers and HMO'S.

Ms. Lower then informed the committee that the 1.5% interest standard is reserved for property and casualty

carriers and their claims and interests are all together different from those who are involved with health and accident claims. She stated "The Committee was given no opportunity to consider the legal or practical ramifications of this change either." "The committee was given less than complete information about payment histories." She also conveyed to the committee that **Sub For SB 600** "as amended creates more problems than it solves and is based on incomplete information provided to the Senate FI&I Committee", and the Senate floor. Ms. Lower offered the KAHP amendment which returns the legislation to the compromise language and consistent with Missouri law.

Questions were asked by Representatives Kirk and Boston.

The last conferee giving oral Proponent Testimony to the committee was Mr. Brad Smoot, Blue Cross Blue Shield/of Kansas. A copy of the written testimony is (Attachment #9) attached hereto and incorporated into the Minutes by reference. Mr. Smoot informed the committee that both "Blues" support the concept of prompt payment of claims. He feels there is merit to a uniform standard of payment for health insurance claims. Customers and providers expect speed in payment of claims. But, most of all, the customers expect only legitimate claims to be paid by their insurer. They not only want legitimate payments, but only for those things their policy covers, only payments for those things truly covered by their policy, only for the contracted amounts and in a cost-effective way. With this, Mr. Smoot told the committee there were concerns with both **Sub SB 600 and HB 3022.** Mr. Smoot also enclosed within his testimony, "Claims Data Summary-1999", for the committee to review. Mr. Smoot related to the committee that the "Blue's" were the state's largest health insurer and they processed over 35 million claims a year. He covered the number of offices and employees employed to process these claims and provide service to the policy holders and public. He also stated they were, "able to exceed te Medicare claims payment requirement (95% within 30 days) by handling 99.7% within 30 days." The average 10.5 days from when they receive the receipt of the claim to the payment. They are able to process high volumes of claims through electronics.

He also brought to the committee's attention that the insurers also have several obligations under both the state and federal laws as well as under the contracts they sign. He then highlighted some or most of the process that a claims handler goes through to process a claim. If there is not adequate information or if information is eliminated all together these factors may lead to a claim not being processed as quickly as other would like to see them. One must remember that insurers are expected to process these claims quickly AND correctly.

Mr. Smoot then discussed the differences between the above aforementioned bills and each of their defects. There was no technical input crafted into these two bills, and he then went on to what he called the "state line" problem. This refers to the differences between the Kansas and Missouri standards. Mr. Smoot explained these differences can and will cause "enormous confusion and programming expense" for the health insurers operating in K.C. Mr. Smoot then gave examples to the committee. Mr. Smoot also described the process an insurer must go through before processing a claim. The process is as such, "...must determine if a claim is to be paid under their policy, an auto insurance policy, workers compensation coverage, Medicare, Medicaid or other coverage." This process is known as the coordination of benefits.. An insurer must determine whether there is an active policy covering the client, the condition treated and services rendered are covered under the policy and then determine if any additional information is needed. Then and only then can a claim be paid.

Mr. Smoot continued on to inform the committee that "Missouri law is extra-territorial, meaning it applies to Missouri residents where ever they are insured or served. **Sub SB 600**, applies to Kansas." The "state line" problem will be expensive and difficult to solve. The standards are what cause the greater concern, not the days and interest. With this Mr. Smoot and his clients recommend the 45 day, 1% formula, recommended by Kansas insurers, providers and regulators. With this Mr. Smoot stood for questions. There were none.

With no further testimonies to be given and no one from the guests or conferees wanting to further address the bill the meeting was then adjourned. The time was 5:10 p.m.

The next meeting will be held March 23, 2000, at 3:00 p.m.

The following conferees offered written Proponent Testimony only and their testimony is attached hereto and incorporated into the Minutes by reference. The written testimony and reference numbers are as follows:

Mr. Bill Sneed, Health Insurance Association of America, Attachment #'s 1[illegible]
Ms. Rebecca Gaughan, Vice President, Medical Society of Johnson and Wyandotte Counties, #12
Ms. Diane Friedemann, Executive Director, Total Medical Management, Mission, Kansas, #13
Ms. Jeanne Payne, Vice President, Blue Cross and Blue Shield of Kansas City, #14
Mr. Charles Wheelen, Kansas Association of Osteopathic Medicine, Topeka, Kansas, #15

approx. 45 people in attendance

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: 3/21/00

NAME	REPRESENTING
Bill Sneed	HIAA
Harriet Hayward	[illegible]
[illegible]	Olathe Medical Center
Ron Gessl	Delta Dental
Ed Robinson	Delta Dental
[illegible]	KMS
[illegible]	KMS
[illegible] MD	KMS
Paul Wardlaw	JoCo [illegible] Co MS.
[illegible]	KATP
Linda McCoursey	KS Ins. Dept.
Gary Stanton	Women's Health Care Network
Tracy Rasmussen	Mid-America Cardiology
JEFF ECKERT	MID-AMERICA CARDIOLOGY
[illegible] Friedmann	United Imaging Consultants
[illegible]	Med. Practice Consultants
Carrie Donovan	KAIA
Steven R. [illegible]	Blue Cross/Blue Shield of KC.
Jeanine M Payne	Blue Cross Blue Shield of KC

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: March 21, 2000

NAME	REPRESENTING
Brad Smart	BCBS
Bill Grosz	Saint Lukes Shawnee Mission H.S.
Cheryl Dillard	HealthNet
Tim Wood	VCHS
Tim McConville	Federico Consulting
Stacy Kramer	WR, Inc.
David Hanson	Ks Insur. Assns
Kevin Davis	Am Family
John Federico	Federico Consulting
Julie ~~[illegible]~~ Hein	Columbia/HCA Healthcare Corp
Ron ~~[illegible]~~ Hein	Columbia/HCA Healthcare Corp
Chris Collins	Kammco

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Linda J. De Coursey, Director of Government Affairs

RE: Sub. For SB 600 and HB 3022 – Prompt Pay Act

DATE: March 21, 2000

Mr. Chairman and members of the Committee:

Thank you for the opportunity to discuss these two bills dealing with establishing a health prompt pay act for Kansas.

Earlier last year, the Kansas Insurance Department heard from providers about their problems collecting payments from health insurers. Although there is wide variety among health insurers in this regard, some health insurers routinely do not pay claims for as long as 120 days. We have learned, for example, from a Lawrence psychology group that their collection rate over the past decade has dropped from 85% to below 50%. And, we have learned that a large specialty group in the Kansas City area has actually had to take out loans to survive because of their problems collecting payments. Given the small margin under which most providers operate, failing to receive prompt payment can be their practice at risk.

This problem is not confined to only Kansas. A May 9, 1999 article from the New York Times revealed that, on average, hospitals in the United States receive payment from the health insurers over 60-days after submitting a claim and that average includes the good, efficient insurers that pay claims promptly.

Hse Ins Comm
3-21-00
Att 1

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Topeka, Kansas 66612-1678

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To address this problem, at least twenty-one states have passed laws requiring health insurers to pay claims promptly. These laws have a variety of timelines – usually 30 to 60 days, and a wide variety of remedies for violations – from light penalties and interest payments to heavy fines and other sanctions.

HB 3022 is the same bill as the original SB 600. Sub for SB 600 includes many provisions set out in SB 575. I have attached a comparison of the two bills: Sub for SB 600 and HB 3022

Sub. For SB 600 represented many hours of discussion, research, and compromise by various groups interested in this topic: Insurance regulators, insurers, providers—hospitals and doctors, and a Senator----and of course, all of us sitting around the table are consumers.

In researching other states' laws, certain areas consistently emerged: 1) Definition section that set out the scope. These definitions either contained clean claim, or not. 2) Time tables in which to file claims, pay claims, and ask for additional information. 3) Penalties were also apparent through out these state laws if the insurer does not pay within the time frames established. In many laws, the insurer is responsible to pay the penalty without the provider having to ask for the payment. The penalty is usually in the form of "interest penalty". Six states use a 18% per annum (1.5% per month); 5 states use a 12% per annum (1% per month); 3 states use a 10% per annum; one uses a 9% per annum; and other states use either their legal rate, prime rate, or a rate tied to the T-bill rate.

Sub. For SB 600 is what the compromise group considered a moderate, sensible, but effective approach to this problem.

- Defines clean claim (same definition as Medicare definition of clean claim).
- Defines claim to mean written proof of loss as defined in existing statutes (K.S.A. 40-2203 (A)(7) or electronic proof that contains the same information.

- Requires health insurers to pay a "clean claim" in 45 days of its receipt of proof of loss **(Senate Committee amended that to be 30 days)**, or
- Requires health insurers to notify providers of the status of the claim either electronically or in writing, and include the date such claim was received, and whether the insurer refuses to pay for part of all of the claim and give the reason for denial, or seek additional information for determining if all or any part of the claim will be reimbursed and what specific information is necessary.
- Requires health insurers to pay interest to the provider at a rate of 1% per month on claims left unpaid after 45 days. **Senate Committee amendment: 1.5% per month on claims left unpaid after 30 days.**
- Requires providers to respond to the insurer's request for additional information within 30 days.
- Require health insurers to pay a claim or send an electronic or written notice specifying reason for denying a claim within 15 days after receiving the additional information.
- Explicitly links this law to the Unfair Trade Practices Act, which allows the insurance commissioner to issue fines and other sanctions for flagrant and conscious disregard of the provisions or with such frequency as to constitute a general business practice.
- Allows for a good faith dispute about the legitimacy of the claim when reasonable basis that claim was submitted fraudulently.
- Allows for the insurance commissioner to adopt rules and regulations necessary to carry out the act.
- Allows a delay in the enforcement date to: January 1, 2001.

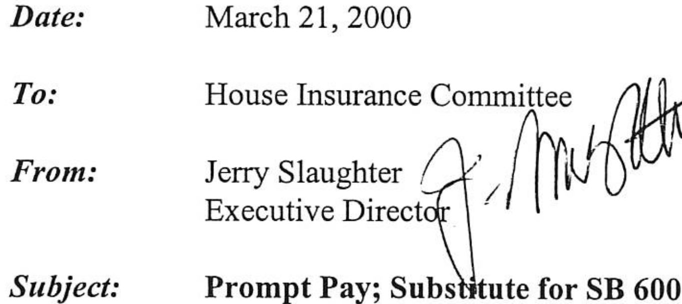
Mr. Chairman and members of the Committee, that is the description of the bill as it passed out of the Senate. One could say that what was prompt pay is now prompter pay. You will be hearing from other conferees about the way the bill came out of committee. In your deliberations of Sub for SB 600, please consider that many insurers, including our most prominent insurers, pay their bills promptly and consistently. But, for those insurers that cause this problem, the bill needs to provide a framework and a series of incentives to ensure that health care bills are paid on time.

Sub for SB 600	HB 3022
Clean claim definition: Medicare definition: "The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment from being made on the claim under this act."	**Clean claim definition:** "Clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the carrier's standard claim form with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements. Except to the extent otherwise required by law, clean claim shall not include a claim for payment of expenses incurred during any period of time in which premium payments to the carrier are delinquent.
Other Definitions: Claim means written proof of loss as defined in current statutes: K.S.A. 40-2203(A)(7). "Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment…." or electronic proof of loss which contains the same contents as 40-2203. (Taken from existing statutes Uniform Policy Provisions K.S.A.40-2201) Applies to the term "policy of accident and sickness insurance" – any policy or contract insuring against loss resulting from sickness, bodily injury, death by accident, or both, any hospital or medical expense policy, health, hospital, medical service corporation contract (stock or mutual or association), HMO, or other insurer; TPA or similar entity Also sets out what term "policy of accident and sickness insurance" does not include.	**Other Definitions:** *Carrier* – means insurance company, medical and hospital service corporation, HMO, managed care plan, PPO, TPA, or entity reimbursing the costs of health care services which hold a valid certificate of authority from the commissioner of insurance *Commissioner of Insurance* means – *Provider* is referenced K.S.A. 1999 Supp. 40-4602 (patient protection act).
Time tables: Proofs of loss: As defined in K.S.A. 40-2203(A)(7) – "proofs of loss: Written proof of loss must be furnished to the insurer within **90 days**. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished **as soon as reasonably possible** and in **no event**, except in the absence of legal capacity, **later than one year** from the time proof is otherwise required."	**Time tables:** Proofs of loss: Clean claim submitted to carrier **within 6 months** from the date upon which a covered service has been provided

Payment of claims: Insurer has 30 days after receipt of claim to: (1) pay or (2) send written notice of refusing to pay all or part of claim and reason for such action, or (3) request additional information. Request for additional information: Provider or person has 30 days after receipt of request. Failure to furnish additional information within time shall not invalidate nor reduce the claim if it was not reasonably possible to give such info in time frame. Within 15 days after receipt of all additional information, insurer must: (1) pay or (2) send notice of denial and reasons.	Payment of claims: Be paid, denied or settled by the carrier within: 30 calendar days if submitted electronically 45 calendar days if submitted by other means. Request for additional information: Carrier shall notify provider within 10 days after receipt of claim (electronically or writing)that carrier (1) refuses to pay all or part or (2) request additional information and state specifically what is necessary. Provider has 30 days after receipt of request submit information. Failure to furnish additional information within time shall not invalidate nor reduce the claim if it was not reasonably possible to give such info in time frame.
Penalties: Insurer shall pay interest on the amount of claim that remains unpaid 30 days after claim is filed at the monthly rate of one and one-half percent. After receipt of additional information and insurer does not pay within the 15 days, insurer shall pay interest on amount of claims that remains unpaid at the month rate of one and one-half percent.	Penalties: Carrier shall pay to the provider interest at a rate of one percent per month on the amount of the claim that remains unpaid after 30 days (electronically) or 45 days (filed by other means). Interest required to be paid shall be included in any late reimbursement made to the person that filed the original claim to make an additional claim for that interest.
Other penalties: Violations of the act triggers unfair trade practices act, K.S.A. 2404, et seq. Penalties range from $100 to $10,000 and ultimately insurer having to surrender license.	Other penalties: Repeated violations of the act: Commissioner may impose against the carrier a civil penalty not to exceed $10,000 after a hearing held in accordance with KAPA.
Civil remedies: No provision	Civil remedies: In additional to other remedies provided by law, a civil action against the carrier for any

	violation of this act. If court finds violation has occurred, the court shall award to a prevailing plaintiff fees, and other expenses determined to be reasonable by rules and regs in addition to the claimed reimbursement and interest, unless the court finds that the position of the carrier was substantially justified.
Undisputed portion of a claim payment required: No provision	Undisputed portion of a claim payment required: Carrier shall pay any undisputed portion of a submitted claim.
Good faith dispute: Interest penalties off if: good faith dispute about the legitimacy of the claim or when a reasonable basis supported by information that such claim was submitted fraudulently.	Good faith dispute: Absence fraud or any action involving external review – all claims shall be paid, denied, or settled in 90 c. days after receipt of claim.
Rules and Regs provision May adopt rules and regs	Rules and Regs provision May adopt rules and regs
Effective date: January 1, 2001	Effective date: July 1, 2000

KANSAS MEDICAL SOCIETY



Date: March 21, 2000

To: House Insurance Committee

From: Jerry Slaughter
Executive Director

Subject: **Prompt Pay; Substitute for SB 600**

The Kansas Medical Society is pleased to have the opportunity to appear today as the committee considers the issue of prompt pay by health insurers. We support this bill and urge your favorable action.

Late payment of claims by health insurers and third party administrators has become an increasingly common problem across our state. In the Kansas City area in particular, we receive numerous complaints from physicians that the problem has become so bad with certain carriers that it has created serious cash flow problems for some clinics. It also creates unnecessary administrative costs and hassles for physician offices, who must spend hours haggling with insurers, resubmitting claims and providing supplementary information in their efforts to receive payment on overdue claims. When insurers and third party administrators fail to pay physicians in a timely manner for services already provided, the physicians basically end up floating interest free loans to delinquent carriers.

While the problem has been confined to a few carriers and third party administrators for now, we believe legislation is needed to prevent the problem from becoming worse. It is apparent to us that current law is either inadequate or unenforceable. The law needs to be clear, easily administered, and enforceable, for it to be effective. Both insurers and the provider community will benefit from a law that clearly spells out the rules and conditions under which claims must be paid on a timely basis. If an insurer cannot pay claims on a timely basis, then the insurer should pay the providers some reasonable penalty for delaying payment on valid claims. By the same token, the insurers have a right to expect that providers will make every effort to submit claims on a timely basis, in an appropriate format, and with necessary documentation.

We believe Substitute for SB 600 goes a long way to improving the situation. For the first time there would be a uniform definition of what constitutes a "clean claim," or a claim that is ready to be paid. Language is also included in the bill to extend the provisions of the act to third party administrators of self-insured health plans, which are a big part of the problem statewide. The bill also establishes a framework of time tables for submitting claims and any necessary additional information requested by carriers. Basically, clean claims would have to be paid within 30 days of being submitted by providers, and in the event additional information is

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requested, then within 15 days of the additional information being submitted. The bill also provides for interest penalties of 1½ % per month (18% annual), and violation of the act will be considered a violation of the unfair trade practices act (K.S.A. 40-2401, *et seq.*) The bill also waives the penalties in the event there is a good faith dispute about the validity of the claim.

In summary, we believe the proposed amendments represent a significant improvement over the current situation, without being unfair and punitive to insurers. It does set out a uniform framework that all insurers must follow to assure that the adjudication and payment of claims is done promptly. We urge your support of this bill.

WESLEY
Medical Center
550 North Hillside
Wichita, Kansas 67214-4976
Telephone 316/688-2468

Testimony re: Substitute for SB 600 & HB 3022
House Insurance Committee
Presented by Jim Sergeant
Vice President of Managed Care
on behalf of
Wesley Medical Center
March 21, 2000

Mr. Chairman:

My name is Jim Sergeant, Vice President of Managed Care at Wesley Medical Center. I am speaking on behalf of the Kansas Hospital Association and Wesley Medical Center. Thank you for the opportunity to comment on the provisions of Substitute for SB 600 & HB 3022, my comments will be based on our experience with SB 600. I want to express the appreciation of our hospital and the Kansas Hospital Association for the efforts put forward on this issue by the Insurance Commissioner, representatives of the insurance companies and managed care companies, the Kansas Medical Society, and several legislators. There had been an ad hoc working group discussing this issue and the legislation, which had resulted in candid discussions about respective concerns, and the group had reached some agreements on various issues and provisions of the bill. Those agreed to amendments were adopted by the Senate Financial Institutions and Insurance Committee. In addition, four other amendments which I will speak to later were also added. I believe that you will hear some concerns raised about those four amendments.

I also want to state for the record, that many of the concerns providers have are not the results of the activities of those insurers or plans that are meeting at the table with us, but from other insurance companies or entities who are not coming forward to try to solve the problem. On behalf of the KHA, we want to extend out appreciation to the insurance companies which stepped forward to provide input into this legislation

Across the country, hospitals and other providers are reporting increasing delays in the payment of claims by health insurers. As the financing of health care services tightens—both for plans and providers—cash flow becomes a significant issue. Ultimately, delayed payment threatens access to health care services if a particular provider's cash flow is insufficient to cover its current operating costs. At the national level, hospital claims languished in accounts receivable an average of 67.1 days in 1998—an increase of 2.6 days from 1995. A recent survey conducted

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by the Kansas Hospital Association found that in Kansas the average days in AR increased from 71 in 1996 to 75 in 1998. At Wesley Medical Center, our days in AR for 1999 were 65 days. This represents a loss of interest earnings due to balance exceeding 45 days of $132,722. Each additional day represents money that is owed to Kansas hospitals, but is unavailable to them to pay staff, bills or interest on debts.

As I indicated above, after all of the parties met, we all came to agreement on some balloon amendments to the prompt pay bill. [Hereafter I will refer to those amendments as the Agreed amendments.] Those Agreed amendments are now all included in Sub SB 600 as they were adopted by the Senate FII committee. The Senate committee also adopted four additional amendments, which were to increase the rate of interest from 1% to 1.5% [at page 2, line 11 and line 33] and to reduce 45 days to 30 days [at page 1, line 41 and at page 2, line 12.] The Agreed amendments had used the 45 days and the 1% interest.

The adopted amendments make Sub SB 600 a stronger bill. However we are willing to live with the bill as it was presented to the Senate FII with the Agreed amendments.

In order to make this legislation effective, it will require monitoring and the continued cooperation of health plans, providers and the Insurance Commissioner. But Sub SB 600 provides a good start to solving the problems relating to certain insurers failing to pay providers promptly.

We would strongly urge the Committee to approve Sub SB 600.

Thank you for your consideration of our comments.

Testimony before the Kansas State House of Representatives Insurance Committee
March 21, 2000
Regarding House Bill No. 3022
Paul D. Wardlaw, M.D., Physician Director
Olathe Medical Services, Inc.

As a representative of physicians in Johnson and Wyandotte County I wish to express support for this bill which will require payers to make prompt payment for claims submitted in appropriate form. Additionally, I would encourage some consideration for strengthening of this bill. The following points express our concerns.

- SB 600 that has already passed the Senate provides for payment within 30 days on all claims as is specified in the current Kansas law, Section 40-2, 126 of Kansas Statutes (Timely payment of claims). I would urge that HB 3022 use the same 30 day limit. One insurance company covering a large number of lives in the eastern Kansas area has admitted in its recent negotiations with physicians that they should be able to respond within at least 15 days to claims that are submitted electronically. 30 days as specified in SB 600 should be very adequate for both electronic and paper claims.
- Insurance companies have increasingly extended the amount of time between the receipt of the claims to the time of payment. This has led to an increase in days revenue in accounts receivable of 20 to 25 percent in many offices. The effect of this is that the insurance company basically gets an interest free loan from the physicians while the physicians pay interest on loans that they must take out to keep up with the cash flow requirements of operating an office. The penalty should be 1½ % per month as specified in SB 600. This is also consistent with what the current law in Kansas specifies in Section 40-2,126 of Kansas Statutes (Timely payment of claims).
- Untimely payment increases the overhead of running an office. When an office must assign a person to begin to follow up on claims that are outstanding for longer that 30 days, costs begin to immediately go up. It is estimated in our offices that it costs about $35 per claim once we have to begin the research, rework, and refiling of a claim. Some of this work would be unnecessary if there is an incentive for the insurance company to respond in a timely fashion to the claims they receive.
- This bill also provides for the payment of the undisputed portions of a claim in a timely manner. Since many claims may contain multiple services it will enhance timely payment of claims if those services that are not disputed are required to be paid in a timely fashion while the disputed services are further researched and discussed.
- This problem of prompt payment is a national concern and over 30 states have enacted legislation that mandates timely payment by insurers. This bill, modified as I have suggested, addresses the issues with clarity and simplicity. This will assist physicians in their efforts to be a part of the cost containment effort in health care while continuing to give excellent quality health care.

Finally, I urge you to support this bill with the suggested additions. Do not create loopholes and technical issues that will encumber its effective administration. Make certain that all insurance companies providing coverage for Kansans are held to these standards.

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INFORMATION TO SUPPLEMENT BILL SB600 AND SB575

1. Define a clean, submitted claim, as Medicare does and incorporate it in the contracts.
2. Carriers must abide by the official HCFA coding, billing and claims edit protocols, especially if they want to reimburse based on the RBRVS procedure values (whether or not the conversion factor is different).
3. Recognize all electronic claims to be acknowledged in 24 hours, paper claims to be acknowledged within 10 days.
4. Require that all managed care organizations be able to accept electronic claims directly or through a clearinghouse by a certain date (which is how Medicare got automated).
5. Providers to be notified within 10 days of any claim pended for any reason, and what the reason is.
6. Providers to be paid within 10 days after receiving additional information, or within 30 days for electronic claims, 45 days for paper claims, whichever is later.
7. Providers must be paid for any undisputed item on a claim according to the above guidelines. (If they can deny by line item, then can pay the same way)
8. All items on claims not paid timely according to the above will have interest added on to the payment of 1.5% per month from the date of the initial receipt.
9. All claims should be paid, denied or resolved in 90 days from the date of the initial claim, which the Carrier must track. Any item paid after 90 days from receipt of a clean, complete claim, must be paid at full charge.
10. Networks must be held accountable for their delays, system flaws and edits as well, either directly to the providers or indirectly to the payers to pass on to the providers.
11. Impartial arbitrator panels must be used to resolve claim disputes, which should be resolved within 60 days of appeal.
12. Civil penalties for violating the act, and payment of legal fees for the provider bringing action if the provider prevails.
13. Credentialing time needs to be shortened to 30 days, or provisions made for temporary numbers to allow payment until the permanent number/approval is given.
14. Standardized credentialing form needs to be mandated for all carriers doing business in Kansas.
15. Managed care contracts need to have indemnity clauses removed, so that each party will be governed by common law indemnity, and the physicians are not left without malpractice or contractual liability coverage.

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March 21, 2000

The Honorable Robert Tomlinson
State Capitol Building
Room 112-S
Topeka, KS 66612

Dear Representative Tomlinson:

I have previously sent you copies of letters discussing our firm's chronic problems with getting paid by area insurance companies and their unfair business practices. Those letters contained examples of deceptive business practices as well as hard data showing the growing payment delinquencies over time. As we speak, a review of the accounts receivable for our top commercial payors shows that 50%-65% of our outstanding claims are more than 30 days old.

Our group stands behind legislation like SB 600 and HB 3022 which will require payors to transact business fairly and timely. We also want your committee to seriously consider the following information before you enact new legislation:

1. **Interest penalties by themselves do not work.** Our delinquent Accounts Receivable have grown since Missouri enacted prompt pay legislation requiring the payment of interest. Insurance companies will continue to do "business as usual", pay the interest, then either raise consumers' rates or lower providers' payments due to the "increased cost of doing business". Furthermore, the tracking and verification of interest payments, as well as the employee cost of appeals usually outweighs the benefits of winning, especially when you consider the additional staff time and disruption of staff during the appeal process. Neither cost will be reimbursed by the payor under new law. In reality, practices will have to "staff up" if they want to actively appeal all the violations of the law. This will further strain the financial viability of physician practices.

2. **Using HCFA / Medicare as a standard for claim processing is paramount.** It can be effectively argued that if all payors adhered to and consistently applied existing HCFA / Medicare rules for claim acknowledgement, claim processing (including recognition of HCFA established codes & modifiers, bundling of services, etc.), claims denial and appeal processes, and timely payment, a prompt pay law would not be necessary. As it stands, payors create their own rules and apply them arbitrarily. Case in point. BCBSKC does not pay for an EKG interpretation when it is given during an office visit in a cardiology office. They state that the EKG is considered part of the Office visit charge. HCFA disagrees.

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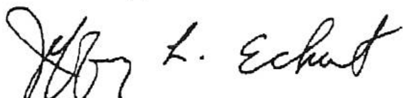
3. **The provider must have prompt recourse for payment**. If payment is not forthcoming from the managed care company or its leased network of payors, the provider must be able to bill the patient. One innovative idea is to have the managed care company carry insurance that will pay the provider directly, and immediately, if proof of non-payment within a certain timeframe is provided to the carrier. Please always remember that physician practices must pay their suppliers within 30 days or the practice will be cut off from the goods needed to see patients, such as syringes, drugs, etc. Our large practice has experienced this problem. Collecting interest when and if the payor decides to remit payment does not help this vendor problem one iota.

4. **Full disclosure is required.** In order to have the ability to enter into healthcare contracts as an informed provider, payors should be required to fully disclose complete fee schedules, patient demographic data, lists of contracted area facilities, and policy and procedure manuals, before contracts are signed. Currently, many payors will state that they do not provide fee schedules in contracts and/or do not require their leased payors to adhere to the same claim processing or other protocols. We experienced variations of these issues with Cigna, BCBSKC and HealthNet. I hope you will agree it is poor business to sign a "blank check". However, due to market forces, that is what insurance companies have the ability to tell providers. The insurance companies are effective at this deceptive/unfair practice due to a relatively fragmented provider panel (anti-trust concerns) which translates into market power for them. They also hide behind the logic that they do not control the payors in their leased networks. These unfair practices must change. These issues also cause increased practice overhead.

The pendulum must swing back to forcing payors to meet their obligations. At the present time, the only way to force such compliance through hard hitting legislation, a class action lawsuit, or an involuntary bankruptcy judgement, all of which are currently under discussion. If current legislation is not substantial as outlined above, I predict you will see practices closing operations, physicians leaving Kansas and Missouri for higher paying jobs, and our most seasoned physicians retiring. Our practice has experienced most of these problems already. If we don't act decisively now, the legislature will be forced to address a much larger payor induced crisis in the near future.

Thank you for allowing our practice to discuss these issues.

Sincerely,



Jeffrey L. Eckert, MBA, CFM, CMA
Chief Financial Officer

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20333 W. 151st Street, Olathe
Kansas 66061 913-791-4200

Date:	February 17, 2000
To:	Senate Financial Institution and Insurance Committee
From:	Jean Garten, FACHE, Director Managed Care, Olathe Medical Center
Re:	Testimony for Prompt Pay Senate Bill #575 and Senate Bill #600

Chairman Don Steffes and Members of the Committee:

First of all I want to thank you for the opportunity to testify in behalf of the need for a prompt payment bill in the State of Kansas. A law is needed to assist providers (both physicians and hospitals) in order that they may continue to provide services in a fiscally sound manner.

Olathe Medical Center is a significant player in the healthcare arena. Olathe Medical Center also owns Olathe Medical Services Inc., a network of 15 primary care clinics employing 58 primary care providers. The current and cumulative impact of delayed payment to Olathe Medical Center, not including the physician practices, is $13.9 Million in receivables over 90 days.

Attached is a listing of 11 major payors in our area and the number of days they average in claims payments. A review of the payors will quickly show you that they are all outside of thirty (30) days. Nine (9) of the payors are outside of seventy (70) days, seven (7) are outside of eighty (80) days and three (3) are outside of 100 days. All of these payors have been notified directly regarding their performance and have been asked to submit a plan of correction. So far we have received little if any assistance in addressing the situation and continue to try to work in good faith in an attempt to resolve the issues. In comparison, Medicare pays on an average of 25 days and has many federal regulations to abide by. They also provide on-line access for claims submission and claims review to assure a clean-claim is transmitted.

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Problems which we have encountered in getting claims paid in a timely fashion with commercial insurers include the following:

Major carriers limit the number of accounts that can be investigated per phone call to three (3) or five (5) claims. They may also restrict the provider from faxing responses for additional information.

Also common among payors is the edits for coordination of benefits information from the subscriber. When the insurer is unable to get the written response from the subscriber regarding potential for other payor involvement or subrogation, they delay processing or deny the claim for payment

Carriers utilize electronic claims processing vendors which can verify clean claims which have been sent, yet many carriers deny receipt of the claims and require the claim to be resubmitted time and time again, further delaying payment.

Franchise PPO or Networks provide a different challenge in that claims are sent to one location for re-pricing and subsequently sent to the claims payor for adjudication. Claims are often lost in this system, further delaying payment. Additionally, unless the carrier requires prompt payment in their contracts with these payors, the providers have no way of enforcing prompt pay practices.

Some insurance companies accept additional information via fax, however others do not, yet many require copies of invoices separate from the bill to make payment on special items such as expensive implants. This further delays payment.

Comment on the Bills:

Senate Bill #575

This bill does not require timely acknowledgement if a claim is not considered a "clean claim" and additional information is needed. A 10-day timeframe would be preferred to the forty-five (45)-day timeframe.

This bill requires that a provider submit additional information for claims to the insurer within thirty (30) days, however given the provider does not submit the additional information within a ninety (90) day period, it is uncertain as to whether the claim will be denied or paid.

The bill requires that a "provider that is paid interest, must pay proportionate amount of such interest to the enrollee or insured to the extent and for the time period that the enrollee or insured has paid for the services which reimbursement was due to the insured or enrollee." It is unclear what this provision means.

Providers are defined as K.S.A. 1999 Supp. 40-4601. This is not a definition of providers, rather is a definition of the Kansas HealthCare Stabilization Act passed in 1999.

There is nothing in the bill that legislates prompt payment from third parties that the carrier enters into relationships with for the purpose of offering discounted services. This can include PPO, ERISA and self-funded business which represents a large accounts receivables problem for us when claims are not paid on a timely basis.

Senate Bill #600

Although we appreciate the efforts made by Commissioner Sebelius, without further modification, we prefer Bill #~~575~~ 600 as it is clearer in its intent. Additionally, this bill contains the following:

Offers the appropriate definition of provider (K.S.A. 1999 Supp. 40-4602);

Provides for a timeframe on providing acknowledgment of needing additional information;

Does not require providers to calculate interest;

Provides for a fine on insurance carriers that are found to be deliberate in repeated violations.

The only drawback to this bill relates to the language requiring claims to be submitted within a 6-month period. Although providers should not have a problem meeting the requirement to submit a claim within this amount of time, there are extenuating circumstances that should be taken into consideration. Providers should not be expected to write-off total balances for services rendered based on timely filing alone. Services were provided in good faith and payment should also be made in good faith. Given this provision must stay in the bill, it would be suggested that the payors be required to pay full billed charges, (instead of interest), in the event they cannot comply with the prompt payment provisions.

Additionally, in the case of both bills, the following should be considered for inclusion:

This bill should include language that requires the payor to acknowledge when a claim is received via electronic billing. At present, some carriers are deliberately blocking this information or only acknowledging receipt when they have confirmed or logged it into their system. This could include a lag time of up to 10 days (as is our experience). The same situation applies to receipt and confirmation of mailed paper claims.

This bill should be made applicable to Third Party Administrators and other payors that lease such networks and make payment directly to the providers.

This bill should require payors to provide in writing their procedures for prior authorization to treatment and the appeal process for denied claims. The majority of managed care contracts require that the provider abide by their policies and procedures, yet those same payors do not provide this information in advance and only as claims are denied is information provided in response. This puts the providers at a disadvantage in knowing what is expected and in some cases results in the hospital and physician providing services that will never be paid for by either the patient or insurer.

Again and in summary, on behalf of the Olathe Medical Center, I would like to express my sincere appreciation to the legislators at work and a special thanks to Senator Karin Brownlee and Commissioner Sebelius for their efforts in addressing this concern for all providers in the state of Kansas.

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Average Payment Rate By Major Carriers

CARRIER	CARRIER #	DISCHARGE - BILLED DATE	BILLED - PAYMENT DATE AVERAGE
A	310	-22.29	-54.87
B	337	-18.28	-88.36
C	353	-17.61	-88.07
D	345	-21.03	-88.29
E	359	-21.73	-83.4
F	360	-12.38	-149.62
G	365	-26.57	-102.07
H	504	-14.48	-119.45
I	509	-13.82	-72.41
J	521	-15.79	-74.99
K	522	-20.34	-53.08

Jean Garten

From: Debbie Jantsch [djantsch@qni.com]

Sent: Thursday, February 17, 2000 7:39 PM

To: Richard Butin MD; Rick Butin

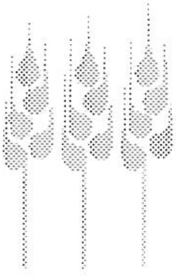
Cc: Jill Watson; Ron Cosens

Subject: Missouri HB 1932

Missouri HB 1932 passed unanimously (21-0) out of committee today and will pass on for floor debate. This legislation deals with strengthening prompt pay requirements---making them legally enforceable, deals with many of the contract fairness Issues we have had such concerns about is KC, and addresses some of the complexities of our delivery system that so hamper the physician and consumer. See the web site for highlights of the Bill. www.metromedkc.org

The testimony given was very strong and the effort is launched. We need your help as always in letting your Kansas City legislators know of your stories on prompt pay and contract fairness. If they are armed with your documentation they can be strong in making informed decisions for their constituents.

Kansas City members of the committee are Representatives Scott Lakin, Pat Kelley, Steve McLuckie, Annie Reinhart, Jewell Patek, and Yvonne Wilson. Don't forget to say thank you. DAJ



Kansas Association of Health Plans

Testimony before the
House Insurance Committee
The Honorable Robert Tomlinson, Chairman
<u>Hearings on Sub for SB 600 and HB 3022</u>
March 21, 2000

Good afternoon Chairman Tomlinson and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, 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 others entities that support managed care. Members of the KAHP serve many of the Kansans who are insured by an HMO.

The KAHP appears today in support of the concept of Sub. for SB 600. The KAHP recognizes the concerns raised in HB 3022, however, we believe Sub. for SB 600 with our proposed amendments is a better vehicle to address the issue of prompt payment. Sub. for SB 600 requires prompt settlement and payment of health care claims. After several months of work, the Kansas Insurance Department, the Kansas Medical Society, the Kansas Hospital Association, the Health Insurance Association of America and the Kansas Association of Health Plans reached agreement on a compromise prompt pay bill. At the urging of one Senate FI&I Committee member, the amendments were added to SB 600 rather than SB 575, so we now have Sub. for SB 600.

Several factors went into the negotiations among the interested parties. Most important, was a thorough discussion of the current law, both federal and state. As part of the compromise, issues important to some parties were dropped and testimony in opposition to the proposal was not offered. Consequently, the Senate Committee did not benefit from the traditional debate over the facts and law which is normally a part of the hearing process. Unfortunately, the amendments adopted by the Senate Committee at last week's hearings and

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consequently passed by the full Senate were not based on a full set of facts or a complete understanding of the law. For these reasons, we urge you, the House Insurance Committee to adopt the original compromise language proposed in our amendments.

With regard to the law, the Senate relied upon assertions made regarding Medicare payment standards. It was indicated that all Medicare claims had to be paid within 14 days for electronic filings and 30 days for paper claims. Actually, federal law uses a 30-day rule as a composite standard. Health plans which administer Medicare and those which sell Medicare Supplement policies must pay 95% of their claims within a 30-day standard. This is a considerably different assessment methodology than is proposed in the prompt pay bill before you today. In other words, no Medicare carrier or administrator is currently required to pay all claims within the standards now amended into SB 600.

In addition, it was asserted that using the Medicare standard would be appropriate since most, if not all, carriers now must honor those federal payment deadlines. As it turns out, there is only one Medicare payer in Kansas (BCBSKS is the Medicare administrator). There are only six Medicare HMO's and only a few of the hundreds of approved health insurers sell Medicare supplement policies. Thus, even if SB 600 were imposing the Medicare payment standards (which it is not), those standards would mean a substantial change for most insurers and many HMO's.

Likewise, during the meeting where the Senate committee worked the bill, a committee member suggested using the 1.5% interest standard found in Kansas law. On the basis of this suggestion, the Committee amended Sub. for SB 600 accordingly. Once again, however, this percentage does not apply to health and accident insurers but is consistently reserved for property and casualty carriers whose claims and interests are considerably different. The Committee was given no opportunity to consider the legal or practical ramifications of this change either.

Following the presentations of medical providers from the Kansas City area to the Senate FI&I Committee, health plans researched their claims experience with those providers testifying before the FI&I Committee. Suffice it to say that the Committee was given less than complete information about payment histories. Since a compromise had been reached with the state associations representing these providers, there was little need to rebut the proponents testimony. Moreover, the concerns of health plans regarding duplicate claims and balance

billing -- issues which affect the cost of health insurance and directly impact health care consumers -- were omitted.

And finally, the compromise was designed to enable health plans in Kansas City area, where most of the complaints seem to originate, to have the same rules for both Kansas and Missouri. Current Missouri law and pending legislation utilize the 45-day rule and the 1% interest rate as was proposed in the compromise to SB 600. The prospect of managing two different standards in the integrated Kansas City metro area is extremely problematic. When the compromise language for Sub. for SB 600 was offered, these problems did not exist. As amended, they do. Unfortunately, the Senate Committee was not given an opportunity to consider the problems associated with managing two different standards in Kansas City. I'm not sure the answers to the problems created can be successfully answered even now. Even if one could determine every hypothetical legal issue presented by the differing laws in the border area, how can health plans be expected to design computer systems to handle them. And at what cost to the insured. We submit that the real cost of this legislation will not be the interest paid to providers for delinquent claims but rather the considerable cost of redesigning computer and claims systems to adapt to differing standards. In an admirable attempt to protect providers, the Senate Committee may have inadvertently ignored or even harmed health care consumers.

Sub. for SB 600, as amended by the Senate, goes too far, creates more problems than it solves and is based on incomplete information provided to the Senate FI&I Committee and then again on the Senate floor. Therefore, the KAHP would offer the following amendments that simply takes the legislation back to the compromise language and make it consistent with Missouri law. I'll be happy to try and answer any questions you may have.

Substitute for SENATE BILL No. 600

By Senator Brownlee

3-10

9 AN ACT concerning insurance; relating to standards for prompt, fair and
10 equitable settlement of health care claims and payment for health care
11 services; establishing an unfair trade practices act violation.
12
13 *Be it enacted by the Legislature of the State of Kansas:*
14 Section 1. This act shall apply to any policy of accident and sickness
15 insurance issued or renewed in this state.
16 Sec. 2. (a) The term "clean claim" means a claim that has no defect
17 or impropriety, including any lack of required substantiating documen-
18 tation, or particular circumstance requiring special treatment that pre-
19 vents timely payment from being made on the claim under this act.
20 (b) The term "claim" means a written proof of loss as defined in
21 paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments
22 thereto, or an electronic proof of loss which contains the information
23 required by paragraph (7) of subsection (A) of K.S.A. 40-2203, and
24 amendments thereto.
25 (c) The term "policy of accident and sickness insurance" means any
26 policy or contract insuring against loss resulting from sickness or bodily
27 injury or death by accident, or both, any hospital or medical expense
28 policy, health, hospital, medical service corporation contract issued by a
29 stock or mutual company or association, a health maintenance organiza-
30 tion or any other insurer, third party administrator or other entity which
31 pays claims pursuant to a policy of accident and sickness insurance. The
32 term policy of accident and sickness insurance does not include any policy
33 or contract of reinsurance, life insurance, endowment or annuity contract,
34 policies or certificates covering only credit, disability income, long-term
35 care, medicare supplement, dental, drug, or vision-care only policy, cov-
36 erage issued as a supplement to liability insurance, insurance arising out
37 of a workers compensation or similar law, automobile medical-payment
38 insurance or insurance under which benefits are payable without regard
39 to fault and which is statutorily required to be contained in any liability
40 insurance policy or equivalent self-insurance.
41 Sec. 3. (a) Within ~~30~~ days after receipt of any claim, and amendments 45
42 thereto, any insurer issuing a policy of accident and sickness insurance
43 shall pay a clean claim for reimbursement in accordance with this section

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or send a written or electronic notice acknowledging receipt of and the status of the claim. Such notice shall include the date such claim was received by the insurer and state that:

(1) The insurer refuses to reimburse all or part of the claim and specify each reason for denial; or

(2) additional information is necessary to determine if all or any part of the claim will be reimbursed and what specific additional information is necessary.

(b) If any insurer issuing a policy of accident and sickness insurance fails to comply with subsection (a), such insurer shall pay interest at the rate of ~~1.5%~~ per month on the amount of the claim that remains unpaid ~~30~~ days after the receipt of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

1.0%

45

(c) After receiving a request for additional information, the person claiming reimbursement shall submit all additional information requested by the insurer within 30 days after receipt of the request for additional information. Failure to furnish such additional information within the time required shall not invalidate nor reduce the claim if it was not reasonably possible to give such information within such time, provided such proof is furnished as soon as possible as defined (within the time prescribed) in paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto.

(d) Within 15 days after receipt of all the requested additional information, an insurer issuing a policy of accident and sickness insurance shall pay a clean claim in accordance with this section or send a written or electronic notice that states:

(1) Such insurer refuses to reimburse all or part of the claim; and

(2) specifies each reason for denial.Any insurer issuing a policy of accident and sickness insurance that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the rate of ~~1.5%~~ per month.

1.0%

(e) The provisions of subsection (b) shall not apply when there is a good faith dispute about the legitimacy of the claim, or when there is a reasonable basis supported by specific information that such claim was submitted fraudulently.

(f) Any violation of this act by an insurer issuing a policy of accident and sickness insurance with flagrant and conscious disregard of the provisions of this act or with such frequency as to constitute a general busi[illegible] practice shall be considered a violation of the unfair trade practices [illegible] K.S.A. 40-2401 et seq. and amendments thereto.

(g) The commissioner of insurance shall adopt rules and regulations

1 necessary to carry out the provisions of this act.
2 Sec. 4. This act shall take effect and be in force from and after Jan-
3 uary 1, 2001, and its publication in the statute book.

9-3

BRAD SMOOT

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Statement of Brad Smoot
Legislative Counsel
Blue Cross Blue Shield of Kansas
&
Blue Cross Blue Shield of Kansas City
House Insurance Committee
Sub Senate Bill 600 & House Bill 3022
March 21, 2000

Mr. Chairman and Members:

Blue Cross Blue Shield of Kansas (BCBSKS) is a mutual insurance company and Blue Cross Blue Shield of Kansas City (BCBSKC) is a medical and hospital service corporation. Both are nonprofit and operate under a certificate of authority issued by the Kansas Insurance Department. Together, they serve a million Kansans. Thank you for this opportunity to comment on Sub SB 600 and HB 3022.

Both Blue plans support the concept of prompt payment of claims. Our customers expect us to efficiently process the provider claims for services rendered to them. Providers, too, have a legitimate interest in prompt payment from insurers. Consequently, there is merit to having a uniform standard of payment for health insurance claims. For that reason, Medicare has a standard for payment followed by many insurance carriers and the Kansas Insurance Department has an administrative rule on the subject (K.A.R. 40-1-34) which governs all carriers. We are accustomed to prompt payment rules and are pleased support and abide by reasonable state requirements.

However, our customers and the providers with whom we contract have additional expectations beyond "speed." They also expect us to pay only legitimate claims, only claims covered by their policies, only in the correct amounts and to do so in a cost-effective way. It is with regard to these expectations that we must raise concern over the terms of Sub SB 600 and HB 3022.

Let us first put the issue of medical claims in context. BCBSKS, the state's largest health insurer processes more than 35 million claims annually. We employ hundreds of dedicated workers here in Topeka to process claims for the 9,906 providers and 887 facilities to whom we made payments last year. Four FTE's are required just to handle the 571,134 duplicate claims submitted by providers for our ordinary business alone. See attached BCBSKS Claims Data Summary - 1999. Yet, in processing this volume of claims, we exceed the Medicare claims payment requirement (95% within 30 days) by handling 99.7% within 30 days. For the state's Medicaid program, our average time was 10.5 days

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from receipt (entry) to payment and for our ordinary insurance business, our average clean claim (no disputes, no complications, complete provider and insured information) was 4.1 days. Even disputed claims average less than 9 days from receipt to payment. Much of this success is attributable to the high volume of claims that can now be processed electronically, although, we still receive thousands of paper claims.

One additional word about claims processing. Health insurers have several obligations under state and federal law, as well as the obligations incurred pursuant to our contracts with our insureds. We are responsible for coordination of benefits. We are the ones who must initially determine if a claim is to be paid under our policy, an auto insurance policy, workers compensation coverage, Medicare, Medicaid or other coverage. This essential function is known as coordination of benefits. We must determine whether the person served, the condition treated and the services rendered are covered under the policy. And we must determine if additional information is required. (BCBSKS reports that only 1.1% of claims filed require additional information.) All this is to say that processing medical claims is not simple and that our policy holders, providers and other insurers, as well as the state and federal government, expect these functions to be performed correctly; not just quickly.

HB 3022 and SB 600, as introduced, were the same. Both contained several flaws which the Senate sought to fix with its substitute bill. For example, HB 3022 contains a definition of "clean claim" which does not recognize the insurer's obligation for coordination of benefits. That defect is corrected in Sub SB 600 (page 1, lines 18-19). Also, HB 3022 limits claims covered by the act to claims submitted within six months of providing the covered service (page 1, lines 30-31). This limits the bill far beyond the current law and practice of one year. This item, too, has been remedied in Sub SB 600. So, although HB 3022 calls for a 45 day limit for paper claims (30 days for electronic) and only a 1% penalty rate, we would urge you to work from Senate Sub for SB 600, if your committee acts on this legislation. With two notable exceptions, Sub SB 600 reflects the input of carriers, providers and regulators in its design. SB 600 and HB 3022 were crafted without such technical input.

There is one remaining issue which deserves your attention. It is what we might call the "state line" problem. The issue is that Sub SB 600 calls for a different standard in Kansas than is applied in Missouri. For health plans operating in the greater KC metro area, this distinction will cause enormous confusion and programming expense. Just how this conflict will be resolved is a real brain teaser. Allow me to illustrate.

Missouri law is extra-territorial, meaning it applies to Missouri residents where ever they are insured or served. Sub SB 600 is different. It applies to policies issued in Kansas. There are several permutations which can result. Some are easy: Kansas insurer; Kansas employer; Kansas resident; and Kansas provider. Which law applies? Answer: Kansas. Others scenarios are more difficult, e.g., Kansas insurer; Missouri employer; Kansas

resident; and Kansas provider. Which law applies? Answer: Neither. Or Kansas insurer; Missouri employer; Missouri resident; and Kansas provider. Applicable law: Missouri. Or how about a Missouri insurer; Kansas employer; Missouri resident; and a Kansas provider. Which law applies? Answer: Who knows. Both states are claiming jurisdiction. This is the classic conflict of laws problem. And, if you think this is merely mental gymnastics, consider how many thousand Kansans work for Missouri employers in the Kansas City area. Or how many Missourians are employed in Kansas. For carriers and their computer programmers, the "state line" problem will be difficult and expensive to solve.

Thus, it is not the number of days and the interest rate, standing alone, which cause concern, but rather, that the standards are different from state-to-state. Our commitment and obligation to process claims as fast as possible is not affected by either version of the bill. However, because of the conflict of laws problem, we must recommend that the House return to the 45 day standard used in Missouri and recommended by Kansas insurers, providers and regulators. See Sub SB 600, page 1, line 41. Likewise, return the bill to the 1% interest penalty (also recommended by Kansas insurers, providers and regulators). See Sub SB 600, page 2, lines 11 and 33.

The Kansas and Kansas City Blue plans endorse prompt payment legislation. However, we urge the House to acknowledge the facts, law and probable costs associated with Sub SB 600 and amend the bill accordingly. Thank you for your consideration of our views.

BCBSKS Claims Data Summary – 1999

Claim Type	Number	
Medicare A&B	15,034,739	% within 30 days/HCFA compliance 99.7%
Medicaid	11,267,025	Average time from entry to payment 10.5
Insured & ASO	9,202,268	Average days/clean – 4.1 Average days disputed – 8.95
Total claims	35,504,032	

Providers served	9,906
Facilities served	887
Duplicate claims processed (ASO & Insured only)	571,134
Claims requiring additional information	1.1%

Other Issues:

- Coordination of benefits (auto, workers comp, Medicare, Medicaid, other coverages, etc.)
- Coverage and benefit levels
- Incomplete information
- Fraud investigations
- Periodic Interim Payments to hospitals

MEMORANDUM

TO: The Honorable Bob Tomlinson, Chairman
House Insurance Committee

FROM: Bill Sneed, Legislative Counsel
Health Insurance Association of America

DATE: March 21, 2000

RE: S.B. 600

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am here today representing the Health Insurance Association of America ("HIAA"). HIAA is the nation's leading advocate for the private, market-based health care system. Our 255+ members provide health insurance to approximately 110 million Americans. We appreciate this opportunity to provide comments on S.B. 600.

HIAA worked with other members of the industry, health care providers, hospitals, and the Kansas Insurance Department in an effort to present a bill to the Senate on a compromise basis. The compromise was presented to the Senate, and my client does in fact support the compromise. However, we would suggest a change to the compromise language in two areas, which we would respectfully request that the House Insurance Committee address.

1. The Senate committee changed the time frame to pay a "clean claim" from 45 days of receipt of the claim to 30 days. Forty-five days is what is generally being used through the country, and for uniformity's sake we would respectfully request that the 45-day time limit be restored.

2. The original bill imposed interest of 1% per month on the amount of claim that remains unpaid thirty days after receipt of a clean claim. The Senate committee increased the interest to 1.5%. Again, most prompt pay bills utilize a 1% interest clause, and as such we

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respectfully request that the House Insurance Committee revert to that language originally agreed to by all parties.

We appreciate the Committee's assistance on this bill, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W. Sneed

Bill: These are the relevant statutes. I am trying to track down Pub. L. 92-41, which apparently is not codified, but so far I have not found a formula. For all we know, the Sec'y of the Treasury pulls a number out of his hat.

MEDICARE STATUTE (TITLE 42)

42 U.S.C. § 1395h (Medicare Part A; identical provisions for Medicare Part B are in 42 U.S.C. § 1395u).

(c) Terms and conditions of agreements; prompt payment of claims

(1) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a) of this section, and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement. The Secretary shall provide that in determining the necessary and proper cost of administration, the Secretary shall, with respect to each agreement, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization in carrying out the terms of its agreement. The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for fiscal intermediaries under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used. The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1395hh of this title, that a fiscal intermediary match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1395y(b) of this title may apply.

(2)(A) Each agreement under this section shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this subchapter -

(i) which are clean claims, and

(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph:

(i) The term ''clean claim'' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this subchapter.

(ii) The term ''applicable number of calendar days'' means -

(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days,

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days, and (FOOTNOTE 1)

(FOOTNOTE 1) So in original. The word ''and'' probably should not appear.

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period ending on or before September 30, 1993, 24 calendar days. (FOOTNOTE 2)

(FOOTNOTE 2) So in original. The period probably should be '', and''.

(V) with respect to claims received in the 12-month period beginning October 1, 1993, and claims received in any succeeding 12-month period, 30 calendar days.

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received from a hospital, critical access hospital, skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency that is not receiving payments on a periodic interim payment basis with respect to such services, interest shall be paid at the rate used for purposes of section 3902(a) of title 31 (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(3)(A) Each agreement under this section shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this subchapter within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph, the term ''applicable number of calendar days'' means -

(i) with respect to claims submitted electronically as prescribed by the Secretary, 13 days, and

(ii) with respect to claims submitted otherwise, 26 days.

PROMPT PAYMENT ACT (TITLE 31)

31 U.S.C. § 3902

"(a) Under regulations prescribed under section 3903 of this title, the head of an agency acquiring property or service from a business concern, who does not pay the concern for each complete delivered item of property or service by the required payment date, shall pay an interest penalty to the concern on the amount of the payment due. The interest shall be computed at the rate of interest established by the Secretary of the Treasury, and published in the Federal Register, for interest payments under section 12 of the Contract Disputes Act of 1978 (41 U.S.C. 611), which is in effect at the time the agency accrues the obligation to pay a late payment interest penalty.

(b) The interest penalty shall be paid for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(c)(1) A business concern shall be entitled to an interest penalty of $1.00 or more which is owed such business concern under this section, and such penalty shall be paid without regard to whether the business concern has requested payment of such penalty.

(2) Each payment subject to this chapter for which a late payment interest penalty is required to be paid shall be accompanied by a notice stating the amount of the interest penalty included in such payment and the rate by which, and period for which, such penalty was computed."

[other subsections not copied]

PUBLIC CONTRACTS (TITLE 41)

41 U.S.C. § 611

"Interest on amounts found due contractors on claims shall be paid
to the contractor from the date the contracting officer receives the claim pursuant to section 605(a) of this title from the contractor until payment thereof. The interest provided for in this section shall be paid at the rate established by the Secretary of the Treasury pursuant to Public Law 92-41 (85 Stat. 97) for the Renegotiation Board."

REFERENCES IN TEXT

Provisions of Public Law 92-41, referred to in text, which authorized the Secretary of the Treasury to fix interest rates for the Renegotiation Board, were contained in section 2(a)(3) of Pub. L. 92-41, which was classified to section 1215(b)(2) of Title 50, Appendix, War and National Defense, and was omitted from the Code. See note preceding section 1211 of Title 50, Appendix.

PROMPT PAYMENT ACT RULE

Federal Register: September 29, 1999 (Volume 64, Number 188)]
[Rules and Regulations]
[Page 52579-52594]
From the Federal Register Online via GPO Access [wais.access.gpo.gov]
[DOCID:fr29se99-21]
[Page 52579]]

Part II
Office of Management and Budget

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5 CFR Part 1315
Prompt Payment; Final Rule
[[Page 52580]]

OFFICE OF MANAGEMENT AND BUDGET
5 CFR Part 1315
RIN 0348-AB47
Prompt Payment
AGENCY: Office of Management and Budget, Executive Office of the President.
ACTION: Final rule on, and codification of, Prompt Payment Act regulations.

Sec. 1315.10 Late payment interest penalties.

(a) Application and calculation. Agencies will use the following procedures in calculating interest due on late payments:

(1) Interest will be calculated from the day after the payment due date through the payment date at the interest rate in effect on the day after the payment due date;

(2) Adjustments will be made for errors in calculating interest;

(3) For up to one year, interest penalties remaining unpaid at the end of any 30 day period will be added to the principal and subsequent interest penalties will accrue on that amount until paid;

(4) When an interest penalty is owed and not paid, interest will accrue on the unpaid amount until paid, except as described in paragraph (a)(5) of this section;

(5) Interest penalties under the Prompt Payment Act will not continue to accrue:

(i) After the filing of a claim for such penalties under the Contract Disputes Act of 1978 (41 U.S.C. 601 et seq.); or

(ii) For more than one year;

(6) When an agency takes a discount after the discount date, interest will be paid on the amount of the discount taken. Interest will be calculated for the period beginning the day after the specified discount date through the date of payment of the discount erroneously taken;

(7) Interest penalties of less than one dollar need not be paid;

(8) If the banking information supplied by the vendor is incorrect, interest under this regulation will not accrue until seven days after such correct information is received (provided that the vendor has been given notice of the incorrect banking information within seven days after the agency is notified that the information is incorrect);

(9) Interest calculations are to be based on a 360 day year; and

(10) The applicable interest rate may be obtained by calling the Department of Treasury's Financial Management Service (FMS) Prompt Payment help line at 1-800-266-9667.

(b) Payment. Agencies will meet the following requirements in paying interest penalties:

(1) Interest may be paid only after acceptance has occurred or when title passes to the government in a fast payment contract when title passing to the government constitutes acceptance for purposes of determining when interest may be paid;

(2) Late payment interest penalties shall be paid without regard to whether the vendor has requested payment of such penalty, and shall be accompanied by a notice stating the amount of the interest penalty, the number of days late and the rate used;

(3) The invoice number or other agreed upon transaction reference number assigned by the vendor should be included in the notice to assist the vendor in reconciling the payment. Additionally, it is optional as to whether or not an agency includes the contract number in the notice to the vendor;

(4) The temporary unavailability of funds does not relieve an agency from the obligation to pay these interest penalties or the additional penalties required under Sec. 1315.11; and

(5) Agencies shall pay any late payment interest penalties (including any additional penalties required under Sec. 1315.11) under this part from the funds available for the administration of the program for which the penalty was incurred. The Prompt Payment Act does not authorize the appropriation of additional amounts to pay penalties.

(c) Penalties not due. Interest penalties are not required:

(1) When payment is delayed because of a dispute between a Federal agency and a vendor over the amount of the payment or other issues concerning compliance with the terms of a contract. Claims concerning disputes, and any interest that may be payable with respect to the period, while the dispute is being settled, will be resolved in accordance with the provisions in the Contract Disputes Act of 1978, (41 U.S.C. 601 et seq.), except for interest payments required under 31 U.S.C. 3902(h)(2);

(2) When payments are made solely for financing purposes or in advance, except for interest payment required under 31 U.S.C. 3902(h)(2);

(3) For a period when amounts are withheld temporarily in accordance with the contract;

(4) When an EFT payment is not credited to the vendor's account by the payment due date because of the failure of the Federal Reserve or the vendor's bank to do so; or

(5) When the interest penalty is less than $1.00.

From: Rebecca Gaughan <rngaughan@pol.net>
To: rep_bob_tomlinson@mail.lsleg.state.ks.us
<rep_bob_tomlinson@mail.lsleg.state.ks.us>
Cc: CSepp@entnet.org <CSepp@entnet.org>
Date: Monday, March 20, 2000 6:04 PM
Subject: HB3022

Dear Representative Tomlinson

I regret I will be unable to testify before your committee tomorrow regarding prompt payment legislation. I started the process with the Insurance Commissioner and then enlisted the help of Senator Brownlee.

As Vice president of the Medical Society of Johnson and Wyandotte Counties I surveyed our membership and found physicians were not being paid for 60 - 120 days. I found out that 43 states now have some type of legislation. This is a serious concern.

Other doctors and I must pay our bills for rent, staff and equipment within 30 days. Our practice has a line of credit we use to cover our expenses until the insurance companies pay what is rightfully owed to us. We are paying interest on the money we borrow to float a loan to the Health Insurance Companies. We need to be paid within 30 days so we do not have to continue to borrow money and pay interest.

This is not an isolated incident. Most physician offices are struggling with late payments in your district. I am sorry they could not come and testify in person.

Insurance Companies can pay their medicare claims claims within 13 days to our office but can't pay their private claims for months. This is not right. Doctors should not be loan agencies for Insurance Companies.

PLEASE HELP STOP YOUR DOCTORS IN KANSAS FROM PAYING INTEREST ON MONEY BORROWED IN HOPES CLAIMS WILL BE PAID BY INSURANCE COMPANIES. OUR MEDICAL SOCIETY SUPPORTS 30 DAY PAYMENT OF CLAIMS WITH SUFFICENT INTEREST TO COVER OUR EXPENSES.

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William Brooks, MD
William Chase, MD
Paul Chesis, MD
Susanne Chow, MD
Stephen Clark, MD
Howard Cloogman, MD
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Robert Schwegler, MD
John Scott, MD
Sarah Sherard, MD
Leo Spittler, MD
Donald Stallard, Jr., MD
Robert Stephenson, MD
David Wood, MD
Robert Wood, Jr., MD
Thomas W. Zinn, MD

March 8, 2000

Good Morning Chairperson Steffes and members of the Senate!

Thank you for allowing representatives from the front lines of the Managed Care Battles to come to you to appeal for reinforcements. My name is Diane Friedemann, Executive Director of Total Medical Management a newly formed Managed Service Organization owned and operated by United Imaging Consultants, LLC., to manage the business of the practice. I have grown up with Medicare in the medical business, having managed hospital and physician billing staffs as well as worked for SMS, a large supplier of hospital billing systems. Medicare was considered the epitome of bureaucracy and inefficiency at that time, but now is considered to be the benchmark of claims processing efficiency!

BACKGROUND:

United Imaging Consultants which I represent, was formed January 1, 2000 from four separate radiology practices in the Kansas City Metropolitan area. UIC employs a total of 34 Radiologists serving patients in 13 hospitals, expecting to perform and bill for 460,000 procedures in our first year of operation. These radiologists, after suffering severe cuts in their reimbursements (from 20% of charges in the 90's to 50% now) have realized that their only hope of surviving, not to mention continuing to render quality patient care, is to join forces to cut costs, maximize resources and reimbursements. Small groups cannot begin to afford the technology and skill levels required to manage the receivables (known as "waging war" in Radiology Business Management circles) given the current Managed Care tactical strategies.

These radiologists are to be commended by the Kansas community, as they chose to maintain their local Kansas Billing office and staffs of 40 employees, while many Physician groups around them have sent their billing out of state in order to be able to drastically cut costs, thinking that this would allow them more profit. In fact, of 15 local Radiology Business offices with managers in this area 5 years ago, only 2 remain. I'm now considered an endangered species! UIC is supporting the local economy not only through those they employ, but those that they contract with for supplies, services, and especially, health insurance benefits. They stayed the course in spite of upward spiraling costs, such as a 22% increase in our Blue Cross Blue Shield premiums, paying high benefit costs to attract and maintain competent staff, paying higher salaries to be able to hire skilled staff in an extremely competitive and tight labor market and paying the higher cost of space and taxes in Johnson County rather than move the office to another state.

WHAT WAS PROMISED

Yet they face daily battles with the national and local Managed Care community, to be paid fairly and timely for their services, if at all. When managed care was originally conceived, providers were told that the advantages would be: guaranteed eligibility verification, guaranteed payment without hassle or uncertainty, prompt payment within 30 days, increased patient flow directed to participating providers and higher payments than non-participating providers. Not even the last promise has been realized.

• Allen County Hospital • Bethany Medical Center • Coffey County Hospital • Lee's Summit Hospital •
• Medical Center of Independence • Menorah Medical Center • Miami County Medical Center • Olathe Medical Center •
• Overland Park Regional Medical Center • Providence Medical Center • Ransom Memorial Hospital •
• Select Specialty Hospital of KC • St. Mary's Hospital Of Blue Springs • Trinity Lutheran Hospital •

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WHAT HAS ACTUALLY HAPPENED

Bureaucratic hassles have quadrupled. It takes two to six months to obtain credentialed, participating status for even a hospital -based and credentialed -physician. In the meantime, we have to hold tens to hundreds of thousands of dollars of claims until we are approved. Our office, both as Deweese Radiological Group, Inc., and now as UIC have attempted for six years to document with letters and dialogue with carriers such as BlueCross Blue Shield of Kansas City, Healthnet, Humana and United Healthcare as to ways to correct their claims processing inefficiencies, flawed system edits, eliminate the Black Holes and pay us correctly and timely. Even while admitting that it cost them more to adjust our claim ($35/adjustment + the cost of the claim!) than to pay it the first time, they steadfastly neglect or refuse to change their processes or systems. The fact that these four major players even have bought new systems that fail to recognize the simplest billing protocol of multiple modifiers, thus causing excessive incorrect claim denials, is evidence of how out of touch they are, or choose to be, with efficient claims processing standards.

It has been estimated in Accounts Receivable Management Publications that Managed Care Plans make 4-5% of their profits on inappropriately rejected claims that are never pursued by appeal, but just written off by the provider. Since a minimum of 10% of our claims are rejected inappropriately and another 5% are "lost", and 20% of them continue to be rejected in spite of valid appeal documentation, I submit that this figure might not be too extreme. We have worked on dozens of claims with United Health Care for as long as two years. We have supplied AMA CPT coding documentation, American College of Radiology coding protocols and Medicare protocols supporting our claim. They have continued to deny the claims and refuse to change their edits. Their profit is earned on the backs of the providers and the subscribers. While they demand that we manage care and follow standard medical protocols, they refuse to manage claims and follow standard (Medicare) billing protocols!

HOW DOES THIS EFFECT HEALTHCARE IN KANSAS?

Two radiologists have left our practice to go to another state due to the pressures in this managed care environment. One of the former groups operated without vacations or Continuing Medical Education time due to financial constraints preventing the hiring of adequate staffing. One former group has to offer a full partner salary to attract a specialist to this area, given the work schedule versus the financial return. As pointed out above, Kansas is losing the Billing Operations to other states. Even the managed care organizations feel the impact of this, because the patient satisfaction drops when having to deal with out of area concerns that don't understand this environment, nor do they seem to care about the patients, only about the dollar. Patients are being put in the position of hospitals participating for the technical component of an x-ray, while the physician providers do not, subjecting patients to higher deductibles and copayments, or full responsibility for the charges. The cost to those patients with Indemnity insurance or private funds will continue to be raised to help cover the costs not paid by managed care. Thus, the patients will be paying more for health insurance, the managed care organizations will be taking more money from the patient and the provider, and continuing to mismanage it, while the providers start retiring, moving, quitting practice, or otherwise limiting the patients options for quality care.

RADIOLOGISTS' ISSUES WITH MANAGED CARE BUSINESS

Attached is a list of specific issues and documented concerns to support our call for a change in the way managed care organizations are allowed to conduct business in the state of Kansas.

WHAT YOU CAN DO TO HELP

United Imaging Consultants and Total Medical Management supports a combination of requirements in both bills (SB600 and SB575) before this membership, namely:

1. Define a clean, submitted claim, as Medicare does and incorporate it in the contract.
2. Carriers must abide by the official HCFA coding, billing and claims edit protocols, especially if they want to reimburse based on the RBRVS procedure values (whether or not the conversion factor is different).
3. Require all electronic claims to be acknowledged in 24 hours, paper claims to be acknowledged within 10 days.
4. Require that all managed care organizations be able to accept electronic claims directly or through a clearinghouse by a certain date (which is how Medicare got automated).
5. Providers to be notified within 10 days of any claim pended for any reason, and what the reason is.
6. Providers to be paid within 10 days after receiving additional information, or within 30 days for electronic claims, 45 days for paper claims, whichever is later.

7. Provider must be paid for any undisputed item on a claim according to the above guidelines. (If they can deny line item by line item, they can pay the same way)
8. All items on claims not paid timely according to the above will have interest added on to the payment of 1.5%/month from the date of initial receipt.
9. All claims should be paid, denied or resolved in 90 days from date of the initial claim, which the Carrier must track Any item paid after 90 days from receipt of a clean, complete claim, must be paid at full charge.
10. Networks must be held accountable for their delays, system flaws and edits as well, either directly to the providers or indirectly to the payers to pass on to the providers.
11. Impartial arbitrator panels must be used to resolve claim disputes, which should be resolved within 60 days of appeal.
12. Civil penalties for violating the act, and payment of legal fees for the provider bringing action if the provider prevails.
13. Credentialing time needs to be shortened to 30 days, or provisions made for temporary numbers to allow payment until the permanent number/approval is given.
14. Standardized credentialing form needs to be mandated for all carriers doing business in Kansas.
15. Managed care contracts need to have indemnity clauses removed, so that each party will be governed by common law indemnity, and the physicians are not left without malpractice or contractual liability coverage.

Thank you for your patience and consideration in listening to the war stories of this somewhat battle-fatigued Lieutenant. I pray that it will assist you in designing wise legislation to address the managed care conflict. If it is possible that I have left any question unanswered, I would be happy to address them now or subsequently. I may be reached at the number shown on the letterhead of my testimony.

MANAGED CARE BUSINESS ISSUES

1. **30% TO 50% DELINQUENT A/R.** Last year, our combined delinquent Accounts Receivable (over 60 days) continued to be well over 30%, with some carriers approaching 50% delinquent claims. This is in spite of electronic billing and INCREASED follow up contacts. Currently, the Deweese Radiological Group receivables ($911,956) are all 60 days old or more, since services were stopped 12/31/99, with billing finished by 1/14/00. Managed Care claims represent approximately $356,000, or 39% of the delinquency. This compares to Medicare which represents only 13% of the delinquency (some of which are also Medicare HMOs). The balance is owed by Medicaid, Indemnity insurance, and self pay. Most businesses consider over 30 days delinquent, which would mean 66% to 75 % is delinquent.

2. **LOST AND PARTIALLY RECEIVED CLAIMS.** A significant contributor to the delinquency of the A/R is the assertion by many payers that they have received "no claim". This is in spite of the fact that we have sent the claim electronically and have received an acknowledgement from the clearing house, or even from the network. This is especially troublesome for Medicare "crossover claims" which Medicare sends to the secondary payer electronically and notifies provider, but the carrier says they didn't receive it. Therefore, we have to print another claim, look up the EOB from Medicare, copy it and attach to the claim, and mail into the secondary payer, all to attempt to collect a payment that is under $5.00! It is interesting, too, that sometimes, the items from a single claim or only partially received, and the others lost. It is especially notable when the lost items are over $500. This may be a system problem, but appears to be more likely due to a chosen edit in the system.

3. **INADEQUATE, FLAWED COMPUTER SYSTEMS.** Major carriers have inadequate (although new) systems to appropriately process claims the first time through. Blue Cross Blue Shield of Kansas City, Healthnet, Humana, Prudential and United Healthcare cannot recognize a second modifier, which is necessary for claims submitted by any Radiology practice in the nation. The second modifiers allow us to process electronically, while indicating that multiples of the same code are not duplicates or unbundled services, but additional exams of the same code or another site. Medicare has recognized these modifiers for at least 5 years. These carriers reject multiple-modifier claims, requiring labor- and resource-intensive refiling efforts for practices. It appears, since we have documented the problem to them for years, that these carriers are banking on the fact that we won't be as persistent for such small dollar amounts, and they will not have to pay these legitimate claims at all. As our practice costs rise, particularly in the labor area, it does become more and more difficult to resubmit these inappropriate rejections, as the research and refiling cost approaches the balance due on the exam.

4. **EDIT SYSTEMS DESIGNED TO DENY CLAIMS INAPPROPRIATELY.** Many carriers utilize flawed edit systems, such as United Healthcare'sGMIS Claimcheck or Healthnet/BlueShield of Kansas City's PACE, which do not follow the AMA CPT coding protocols, as HCFA has mandated for Medicare. Thus, they reject legitimate services, stating that they are included or incidental to another code that has been used, or that it is an "injection" (Prudential) which they include as part of the Radiology Supervision & Interpretation code. Even upon submitting documentation from the AMA CPT Coding Committee, The American College of Radiology, and Medicare, some of these carriers, especially United Health Care, have refused our appeals and will not change their system edits, nor pay the claim. Most notable among the problems are claims that are submitted with a "59" modifier, indicating that this is a second procedure on a separate site, are denied as incidental to the other code. We have had numerous coding audits, and have been supported as coding properly, but it is the carriers whose systems have not been audited for proper coding protocols.

5. **CLAIMS PENDED INDEFINITELY.** A further system problem occurs when carriers pend Physician claims awaiting information from the hospital to be submitted, but when it is received, they fail to release the physician claim unless we follow up by calling.

6. **LABOR INTENSIVE FOLLOW-UP.** That managed care accounts receivable management has become labor intensive is represented by the fact that we have one person to handle Medicare claims follow-up, representing 40% of our business, yet we have to have 3 managed care follow-up people (1 Blue Shield and 2 for other managed care plans) for 33% of our business. In addition, we have two patient representatives to handle the incoming phone calls, mostly from managed care patients.

7. **FLAWED REIMBURSEMENT MODEL.** Our labor costs have risen about 30% over the last several years, while our reimbursements are being cut by 35%to 45%. Medicare, of course, has reallocated division of the Medicare funds among specialties. Medicare also intends to remain budget neutral, no matter that the population grows, that we must render more services to more people, nor that the cost of living has gone up in the Medical Community faster than overall, nor that we have actual costs that have increased disproportionately since the RBRVS was developed. For instance, certified coders that are now practically mandated for a Practice to be operating by a model Corporate Compliance Plan, cost a minimum of $14/hour. Clerical staff with specific skills in medical terminology, managed care protocols and billing regulations, have to be paid more than the local Arby's employee ($9.00/hour). Yet, a few years ago, the government discontinued a separate conversion factor for the practice and malpractice costs for Johnson and Wyandotte Counties in Kansas, and lumped us in with rural Kansas. Does anyone think that the cost of space, supplies and personnel in Johnson County Kansas is as low as it is in Western Kansas?? Lower than our counterparts across the state line in Jackson County? Yet, our conversion factor is lower than Missouri and only equal to rural Kansas, and most of the managed care organizations are basing our payments on this flawed value and conversion factor.

8. **REIMBURSEMENTS NOT LINKED TO COST BENEFITS FOR PROVIDER.** We could still survive on Medicare reimbursements because we have the following benefits that we receive in return: high volume, guaranteed and verifiable eligibility, electronic claims processing, electronic remittance, 14-day adjudication of our claims, resulting in either payment or specific denial, electronic claims status, normally less than 8% claims delinquency, no referrals nor precertifications needed, and a standard, known and published set of rules to code and bill by. However, Managed Care Organizations are attempting to drive our reimbursements down to this level, when they are not willing to offer hardly any of these benefits, not to mention allow our practice to survive. The managed care organizations are forcing the providers to carry the brunt of their losses due to the price wars they engage in for premiums, and the total inefficiency of their systems and organizations outlined above.

9. **NO NETWORK ACCOUNTABILITY.** Managed Care Networks are particularly evasive from an accountability standpoint. Claims are electronically transmitted to the Network for pricing. Then, they drop it to paper to forward to the Payer. If this process becomes backlogged, as it currently is, the Payer may not receive our claim for 30 days. The payer then assumes they have 45 days to pay it without interest, causing us to have a 75 day delinquency, before we are even eligible for interest. (We have yet to see any interest from any of the Payers in the Healthnet or PHP networks.) Moreover, the Pricing Networks are not held accountable for their delinquency or the related late payment to the Provider. Furthermore, the payer can avoid being pinned down to a clean claim by asserting that they did not receive the claim, or the referral from the hospital, or information from the patient or another provider (it too gets "lost"), it was a duplicate or unbundled (modifier issue), etc., etc., etc.. We frequently are not even advised if they pend a claim or even when they apply it to the deductible. We are left to follow-up by phone or letter, since we are not supposed to bill the patient until we have a definite adjudication from the Managed Care Payer.

10. **PATIENTS AND PROVIDERS CAUGHT IN THE MIDDLE.** Hospital Based Physicians are put in a difficult position between the Hospital, Managed Care Plan and Patient. If the hospital contracts with the HMO for what is a financially viable amount for them, but the Plan won't pay us a fair market amount, so we don't participate, the patient winds up with the Technical Component paid at a Participating Rate, and the Professional Component paid at a reduced rate or not at all. Many States are mandating that the Managed Care Payers have to pay the Hospital Based Physicians reasonable and customary charges if the Hospital participates.

11. **UNREASONABLE, UNILATERAL CONTRACT WORDING.** Many of the contracts are presented to providers with no opportunity to have input or agreement to any portion of the contract—an all or none decision must be made. Contracts are necessarily to be an agreement among parties, but it is often like being drafted into the Army—you have few choices. Yet, if we sign contracts with indemnity or hold harmless provisions in it, our physicians would be held personally liable to indemnify the managed care plan, since malpractice coverage will not allow coverage in this situation. If they would remove these clauses, common law indemnity provisions would apply and serve the same purpose, but allow each organization's malpractice to cover them. Most of them will not allow any wording to hold them accountable for prompt payment or rules to receive payment. Most of them can materially change your reimbursement without notice, opportunity to cancel or renegotiate if dissatisfied with the amount they expect Board Certified Physicians to work for. Most of these contracts have unqualified personnel deciding what is medically necessary and under what codes. Most of them do not have an appeal mechanism to an impartial panel of arbitrators, or even a jury of peers from the American College of Radiology who sits on the AMA committee to establish and define the CPT codes and values.

12. **ARBITRARY CREDENTIALING STANDARDS AND FORMS.** Even though by the time a radiologist joins our group, they have to be licensed in the State of Kansas, approved by the DEA, credentialed and privileged by several Joint Commission-Accredited hospitals, and approved by Medicare, we still must submit paperwork again and wait until they wade through yet another backlog, call original sources and yet again verify what has already been verified by all the others, and then obtain a blessing from their credentialing Board. This process takes from two to six months, yet our radiologists must staff all of the hospitals, read all of the films done in that hospital, no matter who the payer is (which they don't know when they are reading the films) and agree to not be paid as participating or not be paid at all for up to six months. Hospital-based physicians need relief from this catch 22. Proof of credentialing by a JCAHO approved hospital should be sufficient, even according to NCQA standards.

Statement of Jeanne Payne, Vice President
Blue Cross and Blue Shield of Kansas City
House Insurance Committee
Substitute Senate Bill 600 and House Bill 3022
March 21, 2000

Mr. Chairman and Members:

Blue Cross and Blue Shield of Kansas City is a Missouri domiciled non-profit health services corporation licensed to do business in the State of Kansas as a foreign carrier under the Kansas law for medical and hospital service corporations.

I am here to express my company's concerns with the "Prompt Pay" Legislation before this Committee. The concern is not that there is statutory recognition that health care providers are entitled to timely payment or that a financial penalty should attach in those instances where there is a failure to meet an external standard codified in statute.

The concern is a Kansas law with a different interest rate and calculation period than the Missouri law and the re-programming costs which would be incurred to respond to the different standards in each State – remembering that these costs are ultimately borne by our subscribers and your constituents.

In my company's specific circumstance, we just recently concluded a two-year, 31 Million-Dollar system conversion of all our non-franchise business to the ERISCO Facets system, a third-party software system.

A Kansas law which a different interest penalty rate and a different time period (30 days rather than 45 days), after which the calculation is triggered has the potential of costing months of staff time and a substantial payment to our vendor for changes to the software system.

Two examples of system implications which would result from passage of the bill in its current form are:

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1) Our system does include functionality to support prompt pay legislation, and we have configured the business rules in the system to support the Missouri criteria. The system does not, however, allow us to code more than one 'rule' per category of member or contract. Because of this, members and contracts will need to be reconfigured to apply only the Kansas criteria for Kansas residents. This will multiply the number of categories in our system, because we currently allow categories to be shared if benefit structures are the same.

2) The automated functionality in the system does not accommodate the rules created around those claims affected under the 'additional information' criteria. We currently (for Missouri) use backend reports for manual interest payments for this claim population. If we have different rules for Kansas with different timeframes, we will be re-coding reports for Kansas and creating additional checks for the same provider. A provider could potentially receive two checks per claim depending upon the state in which the patient resides.

We urge the consideration of the Committee to return to a 1% penalty and a 45 day period before the penalty is triggered.

Kansas Association of Osteopathic Medicine

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Statement
To The
House Insurance Committee
Regarding House Bill 3022
And Substitute Senate Bill 600
By Charles Wheelen
March 21, 2000

Thank you for this opportunity to indicate our support for prompt payment legislation. These bills would establish a standard for payment of properly filed health insurance claims that is similar to acceptable business practices in other sectors of the economy.

We have not conducted a survey of our members to determine the extent to which late payment of health insurance claims occurs, or whether there may exist patterns indicating that the problem is attributable to certain insurers or plans. We do, however, receive occasional inquiries from members who want to know if anything can be done about insurers who delay payment of claims. Our advice to the physician or office manager is to refer to their provider participation agreement to determine if there is provision made for prompt payment. But even if the provider participation agreement includes a clause providing for timely payment, there is very little that the provider can do to enforce such provisions.

We usually suggest that the physician consider one other option; not accept assignment of insurance benefits. In other words, require the patient to pay the physician for services rendered and submit the necessary claims for reimbursement. This option is not popular among physicians and certainly not among patients, but it serves as a reminder that it is the patient who is insured, not the physician. The physician simply accepts assignment of insurance benefits on behalf of the patient, so that the insured can be relieved of the cashflow delay as well as the paperwork associated with reimbursement.

The physician or other health care provider who accepts assignment of benefits provides a valuable administrative service to the patient. House Bill 3022 and Substitute Senate Bill 600 would assure that the health care provider is not penalized financially for providing this service.

While the intent of both bills is the same, there are subtle and important differences. Substitute SB600 defines "clean claim" in part by referencing an existing statutory definition of claim, whereas HB3022 does not. Substitute SB600 defines "policy of accident and sickness insurance" and imposes the prompt payment requirement on those insurers issuing such policies, whereas, HB3022 defines "carrier" and imposes the prompt payment requirement on such carriers. Substitute SB600 requires that all clean claims be paid within 30 days, whereas HB3022 requires that electronically submitted claims be paid within 30 days, but other claims may be paid within 45 days. And the penalty for late payment is 1.5% per month in Sub. SB600, whereas HB3022 imposes a 1.0% per month late payment penalty. Because of those differences, we would favor the provisions of Sub. SB600 over HB3022.

Thank you for considering our comments. We respectfully request that you recommend passage of Sub. SB600.

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