Approved: February 22, 2000
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Senator Don Steffes at 9:00 a.m. on February 17 , 2000 in Room 231-N of the Capitol.

All members were present except:

Committee staff present: Dr. William Wolff, Legislative Research
Ken Wilke, Office of Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Matt All, Kansas Insurance Department
Jim Sergeant, Kansas Hospital Association
Jean Garter, Olathe Medical Center
Dr. Rebecca Gaughan, Physician

Others attending: (See Attached)

Hearing on SB 575–Insurance; prompt payment requirements for insurance companies
Discussion on SB 600–Insurance; prompt payment requirements for insurance companies

Matt All, Counselor to the Commissioner of Insurance, reviewed the problems providers have in collecting payments from health insurers (Attachment 1). Due to the lag time in receiving payment, some providers have resorted to loans to survive because of failing to receive prompt payments. Some hospitals are forced to extreme tactics such as actually driving patients to sign up for medicaid coverage as well as placing pressure on consumers to pay when insurers fail to pay. At least 21 states have passed laws requiring health insurers to pay claims promptly or face fines, interest payments, and other sanctions. Mr. All presented a balloon amendment which would define "clean claim" and make it a violation of the Unfair Trade Practices Act for the insurer to not comply with the proposed legislation. Also included in his testimony was a comparison of **SB 575** and **SB 600**, the bill proposed by Senator Brownlee (Attachment 2).

The Committee discussed the lack of sanctions for repeat offenders in the bill. The proposed bill is modeled after the Missouri bill which has not proven to be particularly effective. The Committee was reminded that doctors cannot legally negotiate for payment or refuse to see a patient because the patient's insurance is slow paying.

Jim Sergeant, vice-president of Managed Care at Wesley Medical Center, spoke on behalf of the Kansas Hospital Association (Attachment 3). He reminded the Committee that as the financing of health care services tightens–both for plans and providers–cash flow becomes a significant issue. Delayed payment threatens access to health care services if a particular provider's cash flow is insufficient to cover its current operating costs. Wesley Medical Center in Wichita has $3.3 million in Accounts Receivable every 45 days. This represents a loss of interest earnings as well as money that is unavailable for daily expenses. He made the following suggestions for improvement on the proposed legislation:

- Establish a way for the health plans to verify receipt of the claim so all parties will know when the 45 days begins.
- Responsibility for paying the penalty is held by the insurance plan, not the provider.
- Add third-party administrators and similar entities to the definitions of insurance plans.
- Define clean claims.
- Late payment of claims should be tied to the Unfair Claims Practices.

It was pointed out that SRS, one of the most serious offenders who is usually up to 120 days late in payment, should be included in those who would pay penalties for late payment. This would include both the managed

care program and the fee for service plans.

Jean Garter, FACHE, Director of Managed Care, Olathe Medical Center, stated that 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 (Attachment 4). Olathe Medical Center has $13.9 million in AR outside the 90 day time frame. She explained that these late bills are dated from the date of the bill from OMC, not the date of dismissal of the patient. Many times there are more than 20 days before the final bill is sent to the patients due to the scrutiny required in bill preparation. Medicaid normally pays within 25 days and the long wait for payment are usually from the insurance companies. Ms. Garter stated their preference for **SB 600** because:

- SB 600 offers the appropriate definition of provider
- Provides for a time frame 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.

Dr. Rebecca Gaughan, representing the Medical Society of Johnson and Wyandotte Counties, said they have failed in their attempt for contract negotiations as none of the carriers in her area will agree to contracts with physicians that state claims will be paid in a certain amount of time (Attachment 5). Approximately 20% of all claims are "lost" electronically. She described the system for checking on claims at the insurance company could take 32 minutes to only address three claims which is usually the limit they allow per call. She said it was interesting in that big claims are lost more often than small claims. Faxes and operating reports are declared lost in order to delay payment of claims. Patients cannot be billed for the cost of service until after their insurance has paid, therefore the time for total payment is extended for months. She also stated preference for **SB 600** because of the penalty clauses.

The Committee requested additional information on mandated cost/loss ratios. The impact on profitability if penalties or sanctions were imposed due to late payment of claims was discussed–would this eliminate competition, would companies be driven out of Kansas? It was pointed out that this slow payment of claims was not unique to the health care industry, it is a system used throughout the business world–operating with "other people's money."

Written testimony was received supporting **SB 600** from the following:

- Bruce B. Snider, M.D. and Susan C. Van Dyke, Olathe Women's Center (Attachment 6)
- Maggie H. Smith, M.D., President of the Medical Society of Johnson and Wyandotte Counties (Attachment 7).
- Senator Brownlee--Prompt payment survey of selected health plans (Attachment 8).

Written testimony was received supporting **SB 575** from the following:

- Larrie Ann Lower, Kansas Association of Health Plans (Attachment 9)
- Charles W. Wheelen, Kansas association of Osteopathic Medicine (Attachment 10)
- Jerry Slaughter, Kansas medical Society (Attachment 11)

The hearing was continued on **SB 575.**

The meeting was adjourned at 10:00 a.m. The next meeting will be held on February 21, 2000.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

GUEST LIST

DATE: 2-17-00

NAME	REPRESENTING
John Federico	Humana
Rich Guthrie	Health Midwest
Robert N. Haylen MD	Medical Society of Johnson Wyandotte Counties
Pat Morris	KAIA
Jerry Slaughter	KMS
Ron Hein	Wesley Medical Center
James R Sargeant	Wesley Medical Center
Jody Kurtenbach	SRS/HCP
Kevin Davis	Am Family Ins.
David Hanson	Ks Insur Assns
Cheryl Dillard	HealthNet
Larrie Ann Lower	KAHP
Brad Smoot	BCBS
Marvin Fairbank	Stormont-Vail HealthCare
Terry Leatherman	KCCI
Nancy Zogleman	Pfizer
Mike Huttles	Ks. Gov't Consulting
Linda DeCoursey	Ks Ins Dept
Matthew All	Ks Ins. Dept
Steve Montgomery	United Healthcare

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

Testimony In Support of S.B. 575
Prompt Pay Bill
Before the Senate Committee on Financial Institutions and Insurance
MATTHEW D. ALL
Counselor to the Commissioner
Kansas Insurance Department
Thursday, February 17, 2000

To the Chairman and members of the committee:

Thank you for having me here today to discuss S.B. 575. This bill proposes a moderate, sensible approach to a significant problem in today's health market: the failure of many health insurers to pay their bills to providers in a reasonable period of time.

We at the Kansas Insurance Department have learned about this problem from both local and national sources. Here in Kansas, we have heard from countless providers about their problems collecting payments from health insurers. Although there is wide variety among health insurers in this regard, it is clear that many health insurers routinely fail to 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 and a half 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 from a

Senate Financial Institutions & Insurance
Date 2/17
Attachment # 1

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particular health insurer. Given the small margin that most providers operate under, failing to receive prompt payment can put their practice at risk.

We should not assume, however, that this problem is confined only to Kansas. Far from it. A May 9, 1999 article from the New York Times revealed that, on average, hospitals in the United States receive payment from health insurers over sixty days after submitting a claim—and that average includes the good, efficient insurers that pay claims promptly. Even the one hundred hospitals considered the "best managed" in the country must wait almost sixty days for payment. These hospitals are forced to resort to extreme tactics—such as actually driving patients to sign up for Medicaid coverage—to avoid financial losses. Unfortunately, these hospitals sometimes resort to placing pressure on consumers to pay when insurers fail to pay. Given the understandable confusion among health consumers regarding who is responsible for what payments in a health transaction, we are troubled anytime a hospital feels it must pressure consumers for payment.

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 from 30 to 60 days—and a wide variety of remedies for violations—from light penalties and interest payments to heavy fines and other sanctions.

In Kansas we propose what we consider a moderate, sensible, but effective approach to this problem. S.B. 575 would do the following:

- Require health insurers to pay a "clean claim" for which there is no dispute over coverage within 45 days of its submission.
- Require health insurers to notify providers of the status of all claims within 45 days. This notice must state that either (1) the insurer refuses to pay for all or part of the claim and a specific reason for each refusal, or (2) additional information is necessary to evaluate the claim and what specific information is requested.
- Require health insurers to pay interest to the provider at a rate of 1% per month on claims left unpaid after 45 days.
- Require providers to respond to the insurer's request for additional information within 30 days.
- Require health insurers to pay a claim or specify reasons for denying a claim within 10 days of receiving the additional information.
- Explicitly link this law to the Unfair Trade Practices Act, which allows the commissioner to issue fines and other sanctions for flagrant or repeated violations.

The approach of S.B. 575 was developed after substantial consultation with knowledgeable sources from the insurance industry and the provider community. Some may argue that the provisions of this bill should be strengthened or weakened, the timeline lengthened or shortened, the interest rate raised or lowered, the penalties stiffened or relaxed. But after our study of other states' approaches and the information we gathered from the market sources, we believe this is the most sensible approach to the problem. It is not onerous, but provides sufficient incentives to deter the bad actors.

In closing, I want to stress that this problem does not extend to all health insurers. Many health insurers, including many of our most prominent companies, pay their bills promptly and consistently. This bill should not affect them at all. But for those other insurers—those that cause this problem—this bill provides a framework and a series of incentives to ensure that they pay their bills on time.

Session of 2000

SENATE BILL No. 575

By Committee on Financial Institutions and Insurance

2-7

10 AN ACT concerning insurance; relating to standards for prompt, fair and
11 equitable settlement of health care claims and payment for health care
12 services.
13
14 *Be it enacted by the Legislature of the State of Kansas:*
15 New Section 1. This section shall apply to any policy of accident and
16 sickness insurance. The term "policy of accident and sickness insurance"
17 as used herein includes any policy or contract insuring against loss re-
18 sulting from sickness or bodily injury or death by accident, or both, any
19 hospital or medical expense policy, health, hospital, medical service cor-
20 poration contract issued by a stock or mutual company or association, a
21 health maintenance organization or any other insurer. The term policy of
22 accident and sickness insurance does not include any policy or contract
23 of reinsurance, life insurance, endowment or annuity contract, policies or
24 certificates covering only credit, disability income, long-term care, med-

(a)

or third party administrator or similar entity which pays claims pursuant to a policy of accident and sickness insurance.
(b)

1-5

25 icare supplement, coverage issued as a supplement to liability insurance,

26 insurance arising out of a workers compensation or similar law, automo-

27 bile medical-payment insurance or insurance under which benefits are

28 payable without regard to fault and which is statutorily required to be

29 contained in any liability insurance policy or equivalent self-insurance.

(c) 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 act.

30 New Sec 2. (a) Within 45 days after receipt of any written proof of

31 loss as defined in paragraph (7) of subsection (A) of K.S.A. 40-2203, and

32 amendments thereto, any insurer issuing a policy of accident and sickness

33 insurance shall pay the claim for reimbursement in accordance with this

clean

34 section or send a written notice acknowledging receipt of the proof of

35 loss and the status of the claim. Such notice shall state that: (1) The insurer

36 refuses to reimburse all or part of the claim and specify each reason for

37 denial; or (2) additional information is necessary to determine if all or any

38 part of the claim will be reimbursed and what specific additional infor-

39 mation is necessary.

40 (b) If any insurer issuing a policy of accident and sickness insurance

41 fails to comply with subsection (a), such insurer shall pay interest at the

42 rate of 1% per month on the amount of the claim that remains unpaid

43 45 days after the receipt of the written proof of loss. The interest paid

1 pursuant to this subsection shall be included in any late reimbursement

2 without requiring the person who filed the original claim to make any

3 additional claim for such interest.

4 (c) After receiving a request for additional information, the person

5 claiming reimbursement shall submit all additional information requested

6 by the insurer within 30 days after receipt of the request for additional

7 information. Failure to furnish such additional information within the

8 time required shall not invalidate nor reduce the claim if it was not rea-

9 sonably possible to give such information within such time, provided such

10 proof is furnished as soon as possible~~, and in no event, except in the~~

~~11 absence of legal capacity, later than 90 days from the time proof is oth-~~

~~12 erwise required~~.

as defined in paragraph (7) subsection (A) of K.S.A. 40-2203, and amendments thereto.

13 (d) Within 10 days after receipt of all the requested additional infor-

14 mation, an insurer issuing a policy of accident and sickness insurance shall

15 pay the claim in accordance with this section or send a written notice that

clean

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

17 (2) specifies each reason for denial. Any insurer issuing a policy of acci-

18 dent and sickness insurance that fails to comply with this subsection shall

19 pay interest on any amount of the claim that remains unpaid at the rate

20 of 1% per month.

~~21 (e) A provider who is paid interest under this section shall pay the~~

~~22 proportionate amount of such interest to the enrollee or insured to the~~

~~23 extent and for the time period that the enrollee or insured has paid for~~

~~24 the services and for which reimbursement was due to the insured or~~

~~25 enrollee. For the purposes of this section, "provider" shall have the mean-~~

~~26 ing ascribed to it in K.S.A. 1999 Supp. 40-4601 and amendments thereto.~~

(e)

27 ~~(f)~~ The provisions of subsection (b) ~~or (e)~~ shall not apply when there

28 is a good faith dispute about the legitimacy of the claim, or when there

29 is a reasonable basis supported by specific information that such claim

30 was submitted fraudulently.

(f) If any insurer issuing a policy of accident and sickness insurance fails to comply with this act, it shall be considered a violation of the unfair trade practices act as defined in K.S.A. 40-2404, et seq. and amendments thereto.

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

32 necessary to carry out the ~~purposes~~ of this act.

provisions

33 Sec. 3. This act shall take effect and be in force from and after its

34 publication in the statute book.

Insurers and Uninsured Put Hospitals in a Squeeze

How to Collect on Stacks of Unpaid Bills?

By MILT FREUDENHEIM

AFTER a run of profitable years, hospitals across the country face cash-flow problems — squeezed, officials say, by slow-paying managed-care companies, cutbacks in government programs and rapidly growing numbers of uninsured patients. Pressured by rising costs, hospitals are aggressively trying to collect mountains of overdue bills for patient care.

According to the hospitals, managed-care companies are routinely delaying payments by three or four months, even in states where delays that long are illegal, often by reporting that they have lost track of bills, including those transmitted electronically.

Adding to their problems, hospitals are feeling the effects of changes enacted in 1997 to the Medicare program, which covers elderly and disabled Americans and supplies more than half the revenue at many hospitals. The changes have reduced the hospitals' share of growth in program payments by billions of dollars.

Across the board, payments for patients plummeted 20 percent last year at the nation's most efficiently managed hospitals, according to preliminary findings by HCIA Inc., a Baltimore company that studies health care trends. By another widely used industry measure, HCIA said that the 100 best-managed hospitals had to wait 64 days last year, on average, to be paid, or five more days than in 1997.

The payment delays, along with rising costs for employees and prescription drugs, are pushing hospitals to seek new price increases, which would add to medical inflation, said John F. Hindelong, a health care analyst at Donaldson, Lufkin & Jenrette.

But before raising rates, hospitals are trying new ways to collect money. They are hiring drivers to take uninsured low-income patients to Medicaid offices to sign up for benefits, combing through Medicare documents seeking overlooked payments, prodding managed-care insurers to pay more promptly and experimenting with ways to collect from patients more efficiently.

"We look under every rock to find money," said John Lavan, executive vice president and chief financial officer of New York **Presbyterian Hospital,** where almost one-third of the unpaid bills are more than four months old.

It is illegal in 21 states for insurers to delay payments to hospitals by more than 30 to 60 days, but it is not uncommon for such laws to be routinely flouted. The pain is especially sharp in New York, where the legal limit is 45 days but managed-care companies typically take three to four months to pay, according to Patricia Wang, a senior vice president of the Greater New York Hospital Association.

Enforcement is spotty and the penalties for late filing have so far been minor; state regulators fined 14 insurers for late payments last month. The biggest penalty so far this year was $91,900 in two fines assessed against **Oxford Health Plans,** hardly a heavy burden for a company with $4 billion in annual revenue. But Leslie Moran, a spokeswoman for the New York State Health Plans Association, said the fines were based on a "miniscule" number of claims among millions handled each month. She said most delays were caused by hospital billing errors.

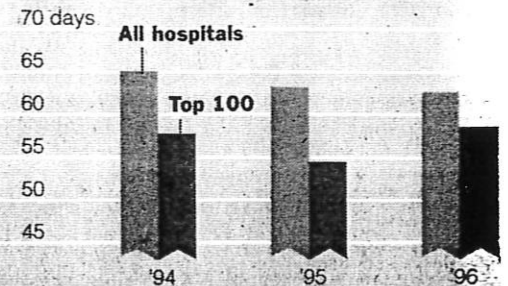
Whatever their cause, the late payments are tying up working capital and will push more hospitals into operating losses if the money is not collected, Ms. Wang said.

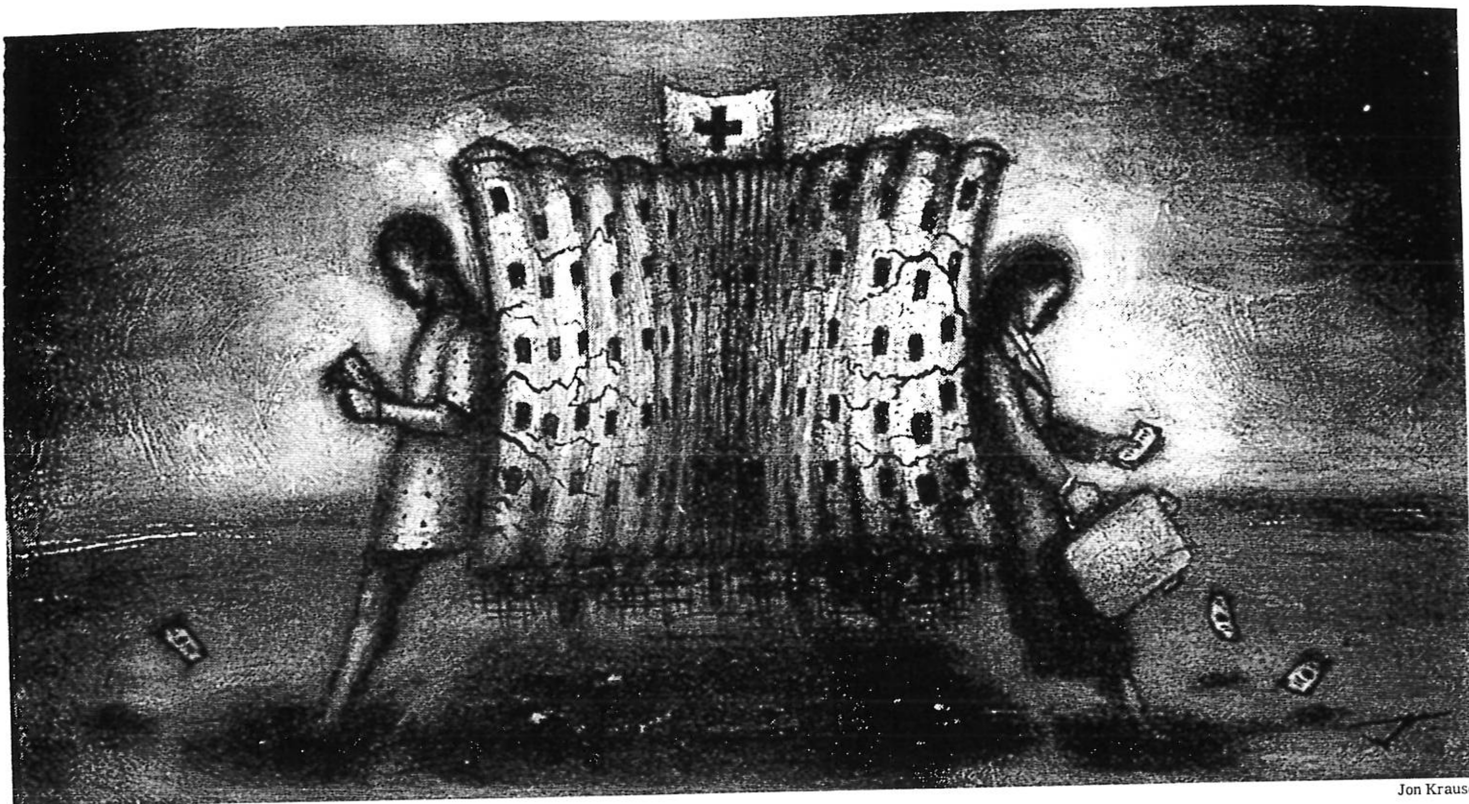
The outlook is almost as dreary elsewhere. The Massachusetts Hospital Association said recently that its members were owed $163 million by health maintenance organizations, of which $122 million was for bills that were 90 or more days old. In Los Angeles, **Cedars-Sinai Medical Center** has more than $270 million in unpaid bills, and it takes 68 or 69 days, on average, to collect, said Bernadette Lodge-Lemon, the director of patient financial services.

Some hospitals have looked for ways to get faster payment on the portion of hospital bills that patients pay themselves. In some cases, they are urging patients to use major credit cards. **Visa** reported 14.5 percent growth in hospital-bill charges to its cards last year, which accounted for $665 million of its $12.1 billion in health care charges; **Mastercard** said its hospital charges were up 10 percent.

But hospital officials say many patients are reluctant to use their credit cards this way. Patients shy away from adding a big, open-ended charge — the total owed may not be known until weeks after the patient goes home — to cards that may already be near their credit limits.

Patients are in no big hurry to pay, either. "The consumer doesn't feel guilty about not paying the hospital, feeling it has gotten paid sufficiently by the insurer," said Dan Cain, a health care investment banker based in New York. And until recently,

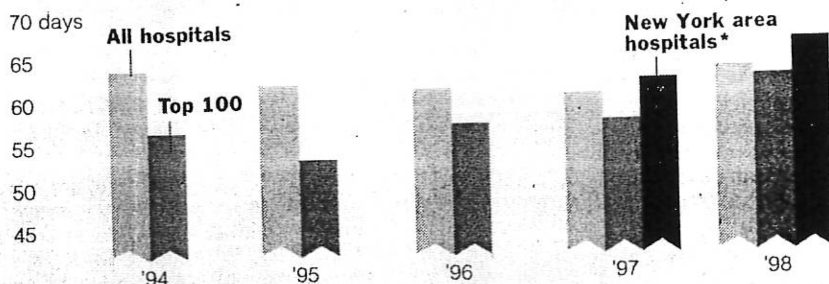




Jon Krause

Waiting Longer for Checks

An important measure of hospitals' financial straits, the average time between issuing a bill and receiving payment, is rising nationwide, and especially in New York. Even the 100 hospitals regarded as the best managed in the country are having increasing trouble receiving prompt payments.



*A survey of 23 hospitals in the New York metropolitan area including teaching hospitals and community hospitals. Figures are not available for earlier years.

Sources: HCIA Inc.; Greater New York Hospital Association

The New York Times

open-ended charge — the total owed may not be known until weeks after the patient goes home — to cards that may already be near their credit limits.

Patients are in no big hurry to pay, either. "The consumer doesn't feel guilty about not paying the hospital, feeling it has gotten paid sufficiently by the insurer," said Dan Cain, a health care investment banker based in New York. And until recently, hospitals, especially nonprofits, have been timid about collecting from patients. "They are very concerned about their public relations," said Ted Smith, a vice president of the American Collectors Association, a Minneapolis-based trade group of credit officers, banks and card companies.

When all else fails, hospitals turn to collection agencies and sometimes sell receivables at discounts to financial firms that are more willing to pursue debtors.

To keep matters from reaching that point, several dozen medical centers have introduced credit cards just for hospital bills. Last fall, the **Atlantic Health System** in New Jersey started offering such a card, managed by **Health Charge**, a privately held finance company in Chevy Chase, Md.

With the card, patients of the system's four hospitals get 60 days to pay without owing interest; thereafter, they are charged the prime rate plus six percentage points, or 13.75 percent as of Friday, a moderate rate by credit card standards. The management company advances the hospital 50 percent of the total bill up front and keeps 5 percent of patients' principal and all interest paid. If the patient does not begin paying in 90 or 120 days, the hospital must return the advance. "It works pretty smoothly, especially for patients that don't have any insurance," said Diane Robinson, who tracks payments for Atlantic Health.

So far, only a small minority of patients are using the cards. Atlantic Health has issued cards to just 150 patients; nationwide, Health Charge has 8,000 card holders at 40 hospitals, according to Paul Devereaux, the company's general manager.

Still, health care is "a huge market that needs capital," said Robert Napoli, a financial services analyst in Chicago with ABN Amro, a Dutch bank. Banks, he added, are "not very good at understanding" health care, creating opportunities for niche players like Health Charge. □

Draft of changes resulting as of meeting on: February 14, 2000

Session of 2000

SENATE BILL No. 575

By Committee on Financial Institutions and Insurance

2-7

or third party administrator or similar entity which pays claims pursuant to a policy of accident and sickness insurance.

(a)(b)

10 AN ACT concerning insurance; relating to standards for prompt, fair and

11 equitable settlement of health care claims and payment for health care

12 services.

13

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

15 New Section 1. This section shall apply to any policy of accident and

16 sickness insurance. The term "policy of accident and sickness insurance"

17 as used herein includes any policy or contract insuring against loss re-

18 sulting from sickness or bodily injury or death by accident, or both, any

19 hospital or medical expense policy, health, hospital, medical service cor-

20 poration contract issued by a stock or mutual company or association, a

21 health maintenance organization or any other insurer. The term policy of

22 accident and sickness insurance does not include any policy or contract

Senate Financial Institutions & Insurance

Date 2/17/00

Attachment # 2

23 of reinsurance, life insurance, endowment or annuity contract, policies or

24 certificates covering only credit, disability income, long-term care, med-

25 icare supplement, coverage issued as a supplement to liability insurance,

(c) 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 act.

26 insurance arising out of a workers compensation or similar law, automo-

27 bile medical-payment insurance or insurance under which benefits are

28 payable without regard to fault and which is statutorily required to be

29 contained in any liability insurance policy or equivalent self-insurance.

30 New Sec 2. (a) Within 45 days after receipt of any written proof of

31 loss as defined in paragraph (7) of subsection (A) of K.S.A. 40-2203, and

clean 32 amendments thereto, any insurer issuing a policy of accident and sickness

33 insurance shall pay the claim for reimbursement in accordance with this

34 section or send a written notice acknowledging receipt of the proof of

35 loss and the status of the claim. Such notice shall state that: (1) The insurer

36 refuses to reimburse all or part of the claim and specify each reason for

37 denial; or (2) additional information is necessary to determine if all or any

38 part of the claim will be reimbursed and what specific additional infor-

39 mation is necessary.

40 (b) If any insurer issuing a policy of accident and sickness insurance

41 fails to comply with subsection (a), such insurer shall pay interest at the

42 rate of 1% per month on the amount of the claim that remains unpaid

43 45 days after the receipt of the written proof of loss. ~~The interest paid~~

New Sec. 3

New Sec. 2. 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 act.

New Sec. 3.

New Sec. 2. 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 act.

2

clean

as defined in paragraph (7) subsection (A) of K.S.A. 40-2203, and amendments thereto.

~~1 pursuant to this subsection shall be included in any late reimbursement~~

~~2 without requiring the person who filed the original claim to make any~~

~~3 additional claim for such interest.~~

4 (c) After receiving a request for additional information, the person

5 claiming reimbursement shall submit all additional information requested

6 by the insurer within 30 days after receipt of the request for additional

7 information. Failure to furnish such additional information within the

8 time required shall not invalidate nor reduce the claim if it was not rea-

9 sonably possible to give such information within such time, provided such

10 proof is furnished as soon as possible~~, and in no event, except in the~~

~~11 absence of legal capacity, later than 90 days from the time proof is oth-~~

~~12 erwise required~~.

13 (d) Within 10 days after receipt of all the requested additional infor-

14 mation, an insurer issuing a policy of accident and sickness insurance shall

15 pay the claim in accordance with this section or send a written notice that

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

17 (2) specifies each reason for denial. Any insurer issuing a policy of acci-

18 dent and sickness insurance that fails to comply with this subsection shall

19 pay interest on any amount of the claim that remains unpaid at the rate

20 of 1% per month.

~~21 (e) A provider who is paid interest under this section shall pay the~~

~~22 proportionate amount of such interest to the enrollee or insured to the~~

~~23 extent and for the time period that the enrollee or insured has paid for~~

~~24 the services and for which reimbursement was due to the insured or~~

~~25 enrollee. For the purposes of this section, "provider" shall have the mean-~~

~~26 ing ascribed to it in K.S.A. 1999 Supp. 40-4601 and amendments thereto.~~

27 (f) The provisions of subsection (b) ~~or (e)~~ shall not apply when there

28 is a good faith dispute about the legitimacy of the claim, or when there

29 is a reasonable basis supported by specific information that such claim

30 was submitted fraudulently.

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

32 necessary to carry out the purposes of this act.

33 Sec. 3. This act shall take effect and be in force from and after its

34 publication in the statute book.

(h)

(g) If any insurer issuing a policy of accident and sickness insurance fails to comply with this act, it shall be considered a violation of the trade practices act as defined in K.S.A. 2404, et seq. and amendments thereto.

SB 575 – Commissioner's Bill	SB 600 – Sen. Brownlee's Bill
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.
Definitions: 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.	**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).

Senate Financial Institutions & Insurance
Date 2/17/00
Attachment 2-7

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 45 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.	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: 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.	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.
Within 10 days after receipt of all additional information, insurer must: (1) pay or (2) send notice of denial and reasons.	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

Interest penalties: Insurer shall pay interest on the amount of claim that remains unpaid 45 days after claim is filed at the monthly rate of one percent. After receipt of additional information and insurer does not pay within the 10 days, insurer shall pay interest on amount of claims that remains unpaid at the month rate of one percent. (this language stricken from 575)…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.	Interest 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 trade practices act, K.S.A. 2404, et seq.	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

550 North Hillside
Wichita, Kansas 67214-4976
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SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
Testimony re: SB 575
Presented by Jim Sergeant
Vice President of Managed Care
on behalf of
Wesley Medical Center
February 17, 2000

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 SB 575. I want to express the appreciation of our hospital and the Kansas Hospital Association for the efforts put forward on this bill and this issue by the Insurance Commissioner, representatives of the insurance companies and managed care companies, the Kansas Medical Society, and several Senators, including Sen. Steffes and Sen. Brownlee. There has been an ad hoc working group discussing this issue and the legislation, which has resulted in candid discussions about respective concerns, and the group has reached some agreements on various issues and provisions of the bill.

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 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.

Senate Financial Institutions & Insurance
Date 2/17/00
Attachment # 3

SB 575 provides a good start to solving this problem. We have also reviewed the provisions of SB 600. However, the KHA has some suggestions that we believe would improve this bill. They are as follows:

1) In order for this prompt pay bill to be effective, there must be a way for the health plans to verify receipt of the claim. This way all parties will know when the 45 days starts.

2) It is also important that the responsibility for paying the penalty be held by the insurance plan not the provider.

3) We would like to note that we support adding third-party administrators and similar entities to the definitions of insurance plans.

4) The addition of a definition of clean claims will also be helpful in making this legislation effective.

5) The late payment of claims should be tied to the Unfair Claims Practices Act (K.S.A. 40-2401 et. seq.) - need teeth to make this work if happens repeatedly.

We understand that the Insurance Commissioner has or will be distributing balloon amendments which would solve most of the concerns we have raised.

In order to make this legislation effective, it will require monitoring and the continued cooperation of health plans, providers and the Insurance Commissioner.

With the balloon amendments, we would strongly urge the Committee to approve SB 575.

Thank you for your consideration of our comments.

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.

Senate Financial Institutions & Insurance
Date 2/17/00
Attachment # 4

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.

Average Payment Rate By Major Carriers

4-5

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

Senate Financial Institutions & Insurance

Date 2.17/00

Attachment # 5

Testimony for Senate Bill No: 600
Before the Senate Financial Institutions and Insurance Committee
February 17, 2000

Chairman Steffes, members of the committee, I am Dr. Rebecca Gaughan representing the Medical Society of Johnson and Wyandotte Counties, as well as the patients I care for as an ear, nose, and throat physician in Olathe, Kansas.

First, I want you to know that physicians in Johnson and Wyandotte County have tried in the past to settle delayed claim payment problems with insurance carriers by contract negotiations. Unfortunately, this has failed miserably. None of the major carriers in our counties will agree to contracts with physicians that state claims will be paid in a certain amount of time. All the contracts state something to the effect that a clean claim will be paid in a timely fashion. Definition of timely fashion apparently is different for insurance carriers than for physicians. For insurance carriers, timely payment can be anywhere from 90 to 365 days or more. For physicians 30 to 45 days seems more reasonable. Physicians do have the option of not signing a contract with a carrier. Unfortunately, I would not be standing here before you today because I would not be able to practice medicine in Johnson County if I did not participate with many of the large carriers. My practice personally has dropped two major carriers in the past year over problems with claims and their contracts. We cannot afford to continue to drop other carriers and stay in business.

I am here today requesting that you consider legislation requiring insurance carriers to pay physicians within 30 days for an electronic claim or 45 days for a paper claim. According to a survey the medical society sent out this summer to 21 physician practices, both small and large, in our area, almost 50% of the claims were not paid within 60 days. Twenty-two percent of claims were over 120 days old. I have enclosed a copy of the survey. This survey proved to the medical society that delay in payment of claims from insurance carriers in our area was not a sporadic event. Delay in payment of claims seems to be part of business as usual.

In our office 20-25% of claims filed electronically with one major carrier are consistently lost. This means we have proof that we filed the claim electronically through our system and that they "received the claim." We will then check back in 45 days to see if they have the claim. We are then told that they never received the claim and we have to file it again. In the past, I had my office call the carrier in 30 days and they were laughed at by the personnel in claims saying, "We don't know in 30 days whether we got your claim or not, call back in two weeks." So, after 45 days and finding out our claim was "lost," we submit a paper claim form, along with proof of our electronic filing to the carrier. We then have another 45 days to find out if that claim was "lost." You see, paper claims are also lost as frequently as electronic claims. Then after playing the 90 day game, our claim may have made it to the insurance carrier. At that point, we are subject to the whim of the claims processing person who can decide that they need more information to pay the claim and can put another delay on the claim. This happens in my practice with very simple procedures that we perform routinely, such as a tonsillectomy. These procedures do not require more information by the carrier. I do not know what other business

Senate FI&I Attachment 5 2/17/2000

would tolerate a 20% loss of the bills that they receive into their office. I doubt that you can call Master Card and say, "I am sorry, I never received the bill. You are going to have to send it again. I don't owe any interest on that payment because I never received the bill."

Now, this is not just a physician problem. One of our patients had surgery in October and we actually submitted the claim four times to a major carrier in our area per the patient's request. She was very interested in paying her bills in 1999 and wanted meet her 1999 deductible. She was very worried that they did not pay the claim by January 2000. She herself personally called the carrier several times. She was told the claim was never sent the first three times. Amazingly, they received the claim the fourth time.

Calls from patients are becoming more common in our practice regarding payment problems from insurance carriers. Patients have cafeteria plans and want to get their part of the bill paid in the same year that they have the illness, injury, or surgery. Not only can we not get the insurance companies to pay claims in a reasonable time period. Patients themselves cannot get the insurance companies to pay the bills.

We, as physicians, are helpless in getting contractual language stating that we get paid in a certain amount of time. We are asking you to pass Senate Bill 600 requiring insurance carriers not only to pay us interest on claims not paid within a certain amount of time, but also to inform of us if they have received the claim and what they are going to do with the claim. We, as physicians, cannot continue to take out practice loans and obtain lines of credit to cover delay in payment from insurance carriers while insurance carriers continue to make interest off of money that is rightfully ours. I do not know any other business entity where this would be tolerated. I am asking you, as a physician in Kansas and as a patient who likes to pay her bills within the same year, to pass Senate Bill 600 requiring carriers to pay physicians and other health care providers in 30 days after an electronic claim and 45 days after paper claim or pay interest. We are also asking that clean claims be defined in the Bill so the definition cannot be changed to meet the carriers' needs.

Unfortunately, even with interest payments, I fear some carriers are going to continue to delay payment to physicians and play the "Lost Claim Game and "This is not a clean claim game" with physician practices. That is why we also support the civil penalty up to $10,000 to be given to the carrier if the insurance commissioner finds that the carrier has repeatedly violated this act.

We as physicians in Johnson and Wyandotte counties appreciate your support, not only for us, but for the patients that we care for.

Practice #	30 days	30-60 days	60-90 days	90-120 days	> 120 days
1	74.9%	13.1%	4.8%	2.6%	4.6%
2	27.7%	28.0%	11.2%	5.8%	27.2%
3	20%	50%	15%	10%	5%
4	32.78%	13.79%	6.8%	7.17%	39.46%
5	34%	14%	14%	18%	
6	62.8%	11.5%	6.2%	7.5%	12.0%
7	63%	21%	7%	2.5%	6.5%
8	4%	15%	25%	24%	13%
9	33.9%	19%	11.8%	6%	27%
10	17%	12%	14%	12%	45%
11A	42.45%	30.59%	11.44%	4.30%	11.22%
11B	35.10%	22.89%	16.99%	7.05%	17.97%
11C	36.50%	37.54%	10.08%	5.30%	10.58%
11D	34.32%	29.06%	13.86%	4.38%	18.38%
11E	5.41%	29.82%	14.25%	10.71%	39.81%
11F	63.74%	13.98%	6.88%	3.56%	11.84%
11G	39.38%	34.23%	12.07%	3.35%	10.97%
12	74%	5%	3%	3%	15%
13	74%	16%	6%	.05%	3.5%
14	17%	8.6%	4.8%	1.3%	2.43%
15	68%	17%	10%	5%	
16	62.8%	11.5%	6.2%	7.5%	12.0%
17	48.2%	15%	5.2%	4%	27.7%
18	63%	24%	13%		
19	39%	18%	20%	10%	7%
20	52%	20%	11%	4%	12%
21	0%	35%	15%	50%	
AVERAGE	57.14%	26.93%	14.07%	10.95%	22.362%

PROMPT PAYMENT BILLS
Summary by Rebecca N. Gaughan, M.D.

SB 600 By Senator Brownlee

1. Clean claim is defined as claim submitted on the carrier's standard claim form with all the required fields completed and correct in accordance with the carrier's published filing requirements.
2. 30 day payment of electronic claims, 45 day payment of paper claims, or 1% interest per month.
3. Carrier given 10 days to notify the provider if additional information is needed.
4. Carrier given 10 days to acknowledge receipt of the claim and status of the claim.
5. Provider has 30 days after receiving request for additional information to reply.
6. All claims (except fraud and external review) shall be paid, denied, or settled within 90 days.
7. Carrier must pay undisputed part of the claim in 30 days electronic or 45 days paper.
8. Carrier must pay legal expenses to provider if the provider has to file a civil action against the carrier for violation of this act.
9. Civil penalty up to $10,000 may be given to the carrier if the commissioner finds that a carrier has repeatedly violated this act.

SB 575 by Committee on Financial Institutions and Insurance

1. Clean claim defined using Medicare definition.
2. 45 days payment of all claims or 1% interest per month.
3. 45 days to notify provider that additional information is needed. (10 days in SB 600)
4. Provider has 30 days after receiving request for additional information to reply.
5. Carrier has 10 days after receiving additional information to pay the claim or deny.
6. Carrier does not pay legal fees to provider if provider has to bring civil action.
7. There is no penalty that can be given by the commissioner if a carrier has repeatedly violated this act.

Olathe Women's Center

20375 WEST 151ST STREET, SUITE 250, OLATHE, KANSAS 66061 (913) 764-6262

February 14, 2000

Hon. Karen Brownlee
Senator 23rd District

Re: Non-Timely Payment By Health Insurance Carriers

Dear Senator Brownlee:

We appreciate your concern on this matter that is very critical to the economic viability of the medical community. Under the aegis of "controlling costs through managed care" the health insurance companies have been mounting what appears to be a coordinated campaign targeting the medical care provider with its central theme being the delinquent payment of claims. From our perspective as obstetric and gynecological physician specialists, we have had both historic and ongoing claim payment delinquencies. Below I have listed a few of the situations:

- Upon closeout of a fiscal year, we had approximately $10,000 in unpaid claims. The tactic used by the insurance carrier was to lose the claims, change the claims manager, or just keep elevating the authorization level. After approximately thirteen submittals of the claims over a three-year period, the final solution was negotiated to a lump sum payment of $3,500. This was done to eliminate the accounting costs of continuing to maintain old records seek payment.

- The insurance carriers appear to have a high turnover rate in their claims processing employees. Quite often when you follow up on a claim that had a question, you find that the individual processing your claim is no longer there and the files are awaiting distribution to other processors.

- Insurance companies contract with third parties to complete either the pricing or paying of claims. This provides them with an additional layer of insulation with which the claim can be processed, reprocessed, and sent back, all of which mean that the claim is not being paid in a timely manner and the insurance company is holding the policy premium.

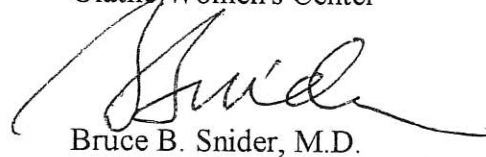
- The insurance carriers frequently inform the healthcare providers that they did not receive the claim. This is a standard first level tactic in delaying payment. It amazes us when we send approximately five claims in one envelope and two are paid promptly and upon inquiry the insurance carrier states that the other three

never were received. We have also had the insurance carrier tell us that the claim was not received when we have sent it registered mail and have the signed return receipt in our file.

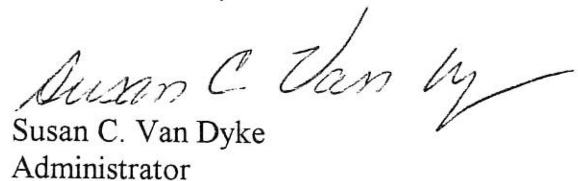
- When we interview our patients prior to submitting a claim, we know if the insurance is primary, secondary, or nonexistent. We report this on our standard HCFA claim forms. The insurance carriers fairly consistently use the phrase "We have requested information regarding potential other insurance from the insured/member. This claim cannot be processed until this information has been received." Following this undetermined period of delay, the claim will often fall into one of the other situations described above.

There is also an underlying theme in the world of collecting your claim from an insurance carrier. When a claim is rejected, denied, or lost, the problem of being paid is the burden of the health care provider. As the unpaid claim is investigated, it routinely concludes that an error or "misinterpretation" was made at the insurance carrier. The effort to clear up the error or "misinterpretation" is always borne by the physician with no ramification for the insurance carrier other than collecting additional interest on the premium held and not paid. Thank you for your interest in this matter that touches us constantly.

Sincerely;
Olathe Women's Center



Bruce B. Snider, M.D.



Susan C. Van Dyke
Administrator

February 15, 2000

Maggie H. Smith, MD
President

Jameson Forster, MD
President-Elect

Rebecca N. Gaughan, MD
Vice President

James H. Utley, MD
Secretary-Treasurer

Paula L. Nauer, MD
Councilor to Kansas Medical Society

Mary L. Redmon, DO
Alternate Councilor to Kansas Medical Society

Robert L. Coleman, MD
Past President

Harriet A. Hayward
Executive Director

The Honorable Karin Brownlee
State Capitol Building
Topeka, Kansas

RE: Senate Bill 600 -

Dear Senator Brownlee

As President of the Medical Society of Johnson and Wyandotte Counties, I am writing in support of SB 600. Prompt Payment must be discussed and defined for both the physicians and the insurance companies. Your bill is an opportunity to establish a standard for prompt, fair and equitable settlement of claims for healthcare and healthcare services. The physicians welcome your interest and involvement in resolving the issue of prompt payment.

Sincerely,

Maggie H Smith, MD

Maggie H. Smith, MD
President

Senate Financial Institutions & Insurance
Date 2/17/00
Attachment 7

6405 Metcalf Avenue, Suite 507 • Shawnee Mission, Kansas 66202 • 913-432-9444 • Fax 913-432-9004 • E-mail medicine@jcms.org

Senate Financial Institutions & Insurance
Date 2/17/00
Attachment 8

SPITAL ASSOCIATION → 9133687119 NO.520 P003

MISSOURI HOSPITAL ASSOCIATION

PROMPT PAYMENT SURVEY OF SELECTED HEALTH PLANS

CONSOLIDATED DATA FOR FOUR MAJOR HOSPITAL SYSTEMS IN ST. LOUIS

AUGUST 1999

	Group Health Plan		Blue Cross		United Healthcare		Total	
	Total Dollar	# of Accounts *	Total Dollar	# of Accounts *	Total Dollar	# of Accounts *	Total Dollar	# of Accounts *
AS OF 12/31/98								
NET REVENUE IN A/R	26,239,054	8,554	33,266,366	17,411	46,870,976	34,661	106,376,396	60,626
PERCENT A/R, 0-30 DAYS	29.6	2,831	37.4	6,980	39.4	9,439	36.4	19,250
PERCENT A/R, 31-60 DAYS	19.6	1,953	21.5	3,586	25.5	8,242	22.8	13,781
PERCENT A/R, 61-90 DAYS	13.0	890	11.1	1,737	12.8	7,131	12.3	9,758
PERCENT A/R, OVER 90 DAYS	38.0	2,880	29.9	5,108	22.3	9,849	28.6	17,837
TOTAL PERCENT	100.0		100.0		100.0		100.0	
AVE DAYS NET REVENUE IN A/R	108.5		80.7		71.2		83.7	
AS OF 3/31/99								
NET REVENUE IN A/R	26,786,731	11,433	40,350,404	18,010	49,778,120	39,276	116,915,255	68,719
PERCENT A/R, 0-30 DAYS	32.8	2,500	39.0	7,143	42.8	12,064	39.2	21,707
PERCENT A/R, 31-60 DAYS	19.4	2,711	20.2	3,907	21.2	8,725	20.4	15,343
PERCENT A/R, 61-90 DAYS	15.0	1,962	11.0	1,994	12.3	6,532	12.5	10,488
PERCENT A/R, OVER 90 DAYS	32.9	4,259	29.7	4,967	23.7	11,956	27.9	21,182
TOTAL PERCENT	100.1		100.0		100.0		100.0	
AVE DAYS NET REVENUE IN A/R	95.5		78.4		65.3		77.1	
AS OF 6/30/99								
NET REVENUE IN A/R	37,624,294	31,439	40,987,184	36,922	47,984,527	51,627	126,596,005	119,988
PERCENT A/R, 0-30 DAYS	32.2	8,563	37.6	14,794	47.3	21,760	39.7	45,116
PERCENT A/R, 31-60 DAYS	18.4	5,502	19.4	6,902	18.8	9,609	18.9	22,013
PERCENT A/R, 61-90 DAYS	8.2	2,486	11.9	3,818	9.9	5,246	10.0	11,550
PERCENT A/R, OVER 90 DAYS	41.3	14,889	31.1	11,408	24.0	15,012	31.4	41,308
TOTAL PERCENT	100.0		100.0		100.0		100.0	
AVE DAYS NET REVENUE IN A/R	117.5		81.2		61.5		85.7	

* Number of accounts was not reported by several hospitals.

Z-8

PROMPT PAYMENT PROJECT FOR ST. LOUIS AREA HOSPITALS

Presentation Points

1. Hospitals in St. Louis have noted disturbing trends in accounts receivable over the past twelve months. This trend has had a significant impact on cash flows to hospitals.

2. The State of Missouri instituted prompt payment legislation requiring 45 days turnaround on clean and complete claims to assure health plan accountability and the financial strength of Missouri's health care providers.

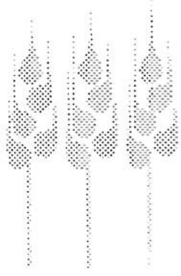
3. In response to these trends, MHA has conducted a survey of the four St. Louis health systems on the timely payment practices of major payers, including Group Health Plan, Blue Cross, and United Healthcare.

4. The survey results show the following:

   a. Net revenue in accounts receivable for all hospitals increased from $106.4 million at 12/31/98 to $126.6 million at 6/30/99.

   b. The number of accounts outstanding for all hospitals increased from 60,626 at 12/31/98 to 119,988 at 6/30/99.

   c. As of 12/31/98, the average days net revenue in accounts receivable for the hospitals with the three health plans was 83.7 days. As of 6/30/99, the average was 85.7 days.



Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
<u>Hearings on SB 575</u>
February 17, 2000

Good morning Chairman Steffes 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 SB 575. This bill requires prompt settlement and payment of health care claims. Throughout the past couple of months we have been involved in discussions with various parties interested in this legislation. We believe SB 575 represents a compromise agreed to by the various parties involved in these negotiations. We have appreciated working with all of the parties involved.

The KAHP recognizes the concerns raised in SB 600, however, we believe SB 575 is a better vehicle to address the issue of prompt payment. If necessary we welcome the opportunity to continue discussion with the various parties on any unsettled concerns. I'll be happy to try and answer any questions you may have.

Senate Financial Institutions & Insurance
Date 2/17/00
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Kansas Association of Osteopathic Medicine
1260 SW Topeka Boulevard
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Phone (785) 234 5563
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Statement
To The
Senate Financial Institutions and Insurance Committee
Regarding 2000 Senate Bill 575
By Charles Wheelen
February 17, 2000

Thank you for this opportunity to indicate our support for SB575. This legislation 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.

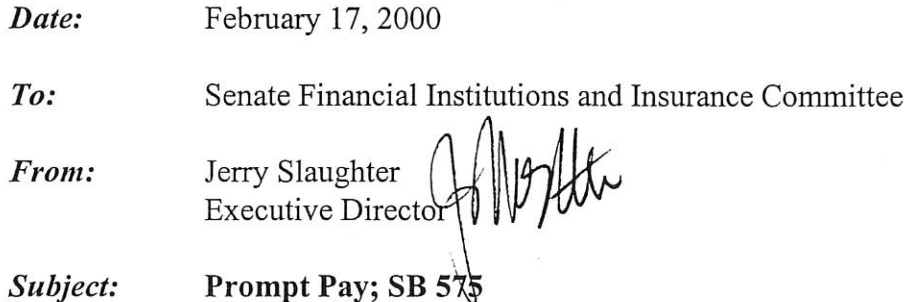
When provider participation agreements include clauses providing for timely payment, there is very little that the provider can do to enforce such provisions. They can either hire expensive legal counsel or contact the Kansas Insurance Department requesting some kind of intervention.

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 paperwork associated with reimbursement.

The physician or other health care provider who accepts assignment of benefits provides a valuable administrative service to the patient. Senate Bill 575 would assure that the health care provider is not penalized financially for providing this service.

Thank you for considering our comments. We respectfully request that you recommend passage of SB575.

KANSAS MEDICAL SOCIETY



Date: February 17, 2000

To: Senate Financial Institutions and Insurance Committee

From: Jerry Slaughter
Executive Director

Subject: **Prompt Pay; SB 575**

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 commend Commissioner Sebelius for taking the lead and introducing legislation addressing this issue.

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 SB 575, with the amendments we understand are going to be offered by the Commissioner, 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. It 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 45 days of being submitted by providers, and in the event additional information is requested, then within 10 days of the additional information being submitted. The bill also provides for interest

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penalties of 1% per month (12% 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 interest penalty 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.