Approved: March 14, 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 March 8 , 2000 in Room 234-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: Tom Bell, Kansas Hospital Association
Linda DeCoursey, Kansas Insurance Department
Jerry Slaughter, Kansas Medical Society
Brad Smoot, BlueCross/BlueShield
Gary Stanton, Women's Health Care Network

Others attending: (See Attached)

Action on SB 549–Cities; depositories of public moneys
Senator Becker moved to report the bill favorably. Motion was seconded by Senator Brownlee. Motion carried.

Continued hearing on SB 575–Insurance; requirement of prompt payment by insurance companies and Continued discussion on SB 600–Insurance; requirement of prompt payment by insurance companies

Linda DeCoursey, Kansas Insurance Department, presented the Committee with a Substitute for **SB 600** which is the product of many hours of research and work with the insurance industry representatives, the providers, and the Kansas Insurance Department (Attachment 1). Tom Bell, Kansas Hospital Association, confirmed that this product is a true working compromise among all parties involved and they were willing to take a "wait and see" attitude. It is probable that this issue will be revisited next year during the Session. Jerry Slaughter with the Kansas Medical Society agreed with Mr. Bell's statement.

The Committee discussed the possibility of having all health insurance companies comply with Medicare standards regarding the filing of electronic claims. Medicare requires that electronic claims be acknowledged and paid within 14 days. Medicare also requires 95% compliance annually rather than enforcing a penalty for individual claims. It was pointed out that not all providers and/or health insurance companies work with Medicare and they were not equipped to meet those standards. Even though the bill does not address Medicare supplement policies, it was pointed out that such policies are under the authority of HCFA and therefore governed by federal law. They require a 99% compliance of timely payment of claims by insurance companies. The 1% per month cap penalty for payments past 45 days was questioned. Is this actually an incentive for insurance companies not to pay until the 44th day? The Insurance Department has no authority over SRS which is notorious for late payments to providers. It was reported that some hospitals have to wait more than 120 days for very large reimbursements from SRS. The Committee also questioned the possibility of private citizens being subject to the penalties if they handled their own insurance and did not pay the provider in a timely manner when they received the check from the insurance company. It was pointed out that providers cannot enforce the payment of a penalty but can add interest onto unpaid invoices.

Gary Stanton, acting as spokesman for United Imaging Consultants of Mission, Women's Healthcare Network, and medical specialty groups in the Kansas City metro area, presented a packet of written testimony explaining the problems they are encountering due to late payments (Attachment 2).

Senator Brownlee made a conceptual motion to have included in the bill the Medicare standards for acknowledgment and payment of electronically filed claims. Motion was seconded by Senator Clark. Motion failed.

The Committee discussed the possibility of the failure of the entire bill if such standards were required as this was not part of the compromise agreed to by the insurance companies, providers, health plan representatives. It was pointed out by Mr. Smoot, BlueCross/BlueShield, that most federal programs do not individualize late claims but look at the aggregate which must meet 95% compliance. It was pointed out that "electronic" is ignored in the proposed legislation.

Senator Barone moved that all references to the rate of interest (penalty) be not limited to 1% but rather be consistent with state law. Motion was seconded by Senator Corbin. Motion failed.

Senator Clark moved for a technical amendment which would renumber and re letter certain sections of the bill. Motion was seconded by Senator Biggs. Motion carried.

Senator Feleciano moved to reduce the number of days from 45 to 30 for receipt of payment and to increase the penalty to 1 ½ % (18% per annum) on unpaid balances for all invoices more than 30 days old. Motion was seconded by Senator Clark. Motion carried.

Senator Feleciano moved that **Substitute SB 600** be reported favorably as amended. Motion was seconded by Senator Brownlee. Motion carried.

Senator Becker moved that the Minutes of March 7 be approved as presented. Motion was seconded by Senator Corbin. Motion carried.

The meeting was adjourned at 10:00 a.m.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: March 8, 2000

NAME	REPRESENTING
Lynn Diston	Phy. Practice
Gary Stanton	Women's Healthcare Network
Diane Friedemann	United Imaging Consultants
Darvin R. Kott	Radiation Oncologists P.C.
Chip Wheelen	Osteopathic Association
Linda DeCoursey	KS Insurance Dept.
Bill Sneed	HIAA
Ron Hein	Wesley Medical Center
Jerry Slaughter	Kansas Medical Society
Chris Collins	"
John Federico	Humana
[illegible]	KTLA
Steve Kearney	KS. PSYCH. SOCIETY
Brad Smoot	BCBS

Session of 2000

SUB. FOR SENATE BILL NO. 600

By Senator Brownlee

2-9

AN ACT concerning insurance; relating to standards for prompt, fair and equitable settlement of health care claims and payment for health care services; unfair trade practices act violation

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

New Section 1. This section shall apply to any policy of accident and sickness insurance issued or renewed in this state. The term "policy of accident and sickness insurance" as used herein includes any policy or contract insuring against loss resulting from sickness or bodily injury or death by accident, or both, any hospital or medical expense policy, health, hospital, medical service corporation contract issued by a stock or mutual company or association, a health maintenance organization or any other insurer or third party administrator or similar entity which pays claims pursuant to a policy of accident and sickness insurance. The term policy of accident and sickness insurance does not include any policy or contract of reinsurance, life insurance, endowment or annuity contract, policies or certificates covering only credit, disability income, long-term care, med-

New Sec. 2 (a)

(b)

dental, drug, or vision-care only policies,

icare supplement, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable without regard to fault and which is statutorily required to be 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.

(d) The term "claim" means written proof of loss as defined in paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto, or electronic proof of loss that contains the identical information.

New Sec. 3.

~~New Sec 2.~~ (a) Within 45 days after receipt of any ~~written proof of loss as defined in paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto,~~ claim, any insurer issuing a policy of accident and sickness insurance shall pay ~~the~~ a clean claim for reimbursement in accordance with this section or send a written or electronic notice acknowledging receipt of ~~the proof of loss~~ 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% per month on the amount of the claim that remains unpaid 45 days after the receipt of the ~~written proof of loss~~ claim. The interest paid

penalty provision

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.

(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~~, and in no event, except in the absence of legal capacity, later than 90 days from the time proof is otherwise required~~.

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

(d) Within ~~10~~ 15 days after receipt of all the requested additional information, an insurer issuing a policy of accident and sickness insurance shall a clean pay ~~the~~ 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% per month.

~~(e) A provider who is paid interest under this section shall pay the 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 and for which reimbursement was due to the insured or enrollee. For the purposes of this section, "provider" shall have the meaning ascribed to it in K.S.A. 1999 Supp. 40-4601 and amendments thereto.~~

(e)

(f) ~~(f)~~ The provisions of subsection (b) ~~or (e)~~ 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) A violation of this act by any insurer issuing a policy of accident and sickness insurance with flagrant and conscious disregard of the provisions or with such frequency as to constitute a general business practice shall be considered a violation of the unfair trade practices act as defined in K.S.A. 40-2404, et seq. and amendments thereto.

(g) The commissioner of insurance shall adopt rules and regulations necessary to carry out the ~~purposes~~ of this act.

provisions

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

January 1, 2001

James Bergh, MD
William Brooks, MD
William Chase, MD
Paul Chesis, MD
Susanne Chow, MD
Stephen Clark, MD
Howard Cloogman, MD
Ira Cox, III MD
W. Bob Davis, MD
George Drasin, MD
Richard Folke, MD
Joseph Goetz, MD
Kelly Hart, MD
Gary Hinson, MD
Douglas Hughes, MD
Kevin Hughes, DO
Marc Inciardi, MD

Timothy Kennedy, MD
Thomas Magee, MD
Mark Mayhle, MD
Charles Medbery, MD
Rick Moritz, MD
Michael Parsa, MD
Ronald Reeb,MD
Gregory Reuter, MD
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

United Imaging Consultants, L.L.C.

5700 Broadmoor, Suite 900
Mission, Kansas 66202
(913) 362-9777
(913) 362- 7667 fax

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.

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.

Accounts Receivable Log
01-01-2000

	0-30 days	31-60 days	61-90 days	91-120 days	over 120 days
Insurance 1	$ 153,549.00	$ 31,489.00	$ 14,021.00	$ 18,475.00	$ 172,550.00
Insurance 2	$ 259,475.00	$ 187,987.00	$ 122,960.00	$ 18,977.00	$ 71,127.00
Insurance 3	$ 129,401.00	$ 15,912.00	$ 23,901.00	$ 9,313.00	$ 118,247.00
Subtotal	**$ 542,425.00**	**$ 235,388.00**	**$ 160,882.00**	**$ 46,765.00**	**$ 361,924.00**
Total AR	$ 1,553,407.00	$ 449,519.00	$ 367,134.00	$ 134,517.00	$ 726,145.00
% AR for 3 Payors	35%	52%	44%	35%	50%

Radiation Oncologists P.C.

Before the Senate Financial Institutions and Insurance Committee
March 8, 2000

Good morning, distinguished members of the Senate. My name is Lynne Deister. I have worked in the healthcare field all of my adult life. Eleven of those years were spent in administration at Bethany Medical Center in Kansas City, Kansas. The last ten have been involved in working with physicians. I am here in support of a strong prompt payment bill that will hold insurance companies accountable.

BACKGROUND:

Over the last few years, many medical physicians have purchased computer systems to assist them in managing their increasingly complex business.

These systems, like those used by other businesses, enable them to do many things better and more efficiently:

schedule patients
follow the patient through the increasingly complex healthcare system
maintain comprehensive medical records
monitor patient satisfaction
send follow-up letters
file insurance claims for the patient with the patient's insurance company, and
keep track of how many times the claim had to be re-filed with the insurance company.

Electronic transmission of medical service claims to the insurance company was supposed to simplify and speed up payment for medical services rendered to patients. I am here to tell you this had not happened. Physician frustration in dealing with insurance companies has become so pervasive that many are now considering premature retirement and leaving the field.

WHAT WAS PROMISED:

Physicians originally agreed to participate with these insurance companies, at a reduced fee, because they were promised "increased volume/patients and improved cash flow". The increased volume was supposed to come because of the "superior offering and panel of providers" being offered by the insurance company. The cash flow was to be improved because "participating providers" would be assured that their claims would be handled correctly and efficiently, without delay, because they were "participating providers".

WHAT ACTUALLY HAPPENED:

None of this has taken place. In the greater Kansas City area, volume is static because the market is largely divided between two major players - HealthNet and Blue Cross Blue Shield of Kansas City. One is controlled by St. Luke's Health System; the other by Health Midwest. Thus, both major insurance groups are controlled by hospital systems. Over the years, each has consistently

offered "low-ball" insurance prices to employer groups and then taken new discounts from physicians after the original discounted contracts were signed.

The health insurance market in the greater Kansas City area moves back and forth from one company to the other every 2-3 years. Depending upon what statistic you believe, each group has between 350,000-400,000 covered lives within the market.

Improved cash flow has never been a reality. In fact, physicians in the metropolitan Kansas City area have never in their history-except perhaps in the Great Depression –had accounts receivable over 61 days at the level they are today. The promised standardized information required by private insurance companies is nonexistent. In this market Blue Cross Blue Shield of Kansas, who is the intermediary for the federal Medicare program, is now the gold standard in accuracy and promptness on payment of medical claims.

Commercial insurance payers have decided to "interpret" diagnostic and billing codes to suit themselves. Within the industry, they use what are commonly called "black box edits". Many items within an insurance claim are interpreted differently by each commercial insurance payer. In short, there is no common standard. Physicians are being dealt as many different payment schemes as airlines have for seat reservations.

We have multiple examples of services being sent on a single claim where some items are paid, accurately and promptly, while others are categorically denied or "lost" after the services have been rendered.

HOW DOES THIS EFFECT HEALTHCARE IN KANSAS?

Insurance claims represent 80-90% of many physicians' business. It now takes dramatically more clerical staff time to deal with these problems than it did just 3 years ago. Ladies and gentlemen, in my nearly one quarter century experience in the healthcare field, I can tell you I have never seen more frustration, anger and discouragement at this state of affairs as I see now. Physicians are leaving the profession in record numbers. That must be very discouraging to you and Kansas citizens when our state still has so many medically underserved areas.

As legislators, you have already dealt with a whole series of other abuses attributed to "managed care". To put this in personal terms, can you imagine how frustrated you would be if the State of Kansas retroactively changed your compensation every week? Can you imagine what that would do to you, your family and your staff if you never knew from week to week what you would receive in your payroll check and whether or not it would cover your expenses?

MEDICAL OFFICES ARE SMALL BUSINESSES

Most small businesses live or die on the basis of a "30 day net" principle. The overwhelming majority of physician practices in Kansas are small businesses by definition. To require Kansas physicians to continue "carrying" these insurance companies for legitimate services rendered in good faith is a sure prescription for driving many physicians out of business in the State of Kansas. Last year in California, more than 100 medical practices went bankrupt or closed. What happened in California is now happening in Kansas and in other parts of the Midwest.

This trend will continue until the Kansas legislature, like legislatures in New York and a dozen other states, passes a law penalizing insurance companies for holding legitimate medical insurance claims for more than 30 days.

I could spend the rest of this morning describing in detail how these insurance company practices are affecting doctors, patients and citizens throughout the State of Kansas. My intent, however, is to be brief, credible and to the point. My recommendation to you is very simple.

WHAT YOU CAN DO TO HELP

I sincerely hope that your Committee and the Kansas legislature will pass and enforce a prompt pay bill, in the current session, which will require all health insurance companies doing business in the State of Kansas to pay legitimate physician service claims within 30 days of receipt or pay appropriate penalties to both physicians and the State for making late payments.

Thank you for allowing me to share these experiences with you. Do you have any questions I might answer?

WOMEN'S HEALTHCARE NETWORK

Before the Senate Financial Institutions and Insurance Committee
March 8, 2000

1. The Women's Healthcare Network, formed in 1996, represents over 70 physicians specializing in obstetrics and gynecology. The Ob/Gyn physician is important to the insurance company provider panel because of the marketability of women's health services to employer groups. Our physicians help to promote the insurance company and in exchange we receive the following:

    A. 176% increase in accounts receivable for claims over 60 days old (8/99 to 1/00).

    B. Days in accounts receivable (A/R) for PPO (Preferred Provider Organization) products as high as 126 days. Days in A/R are 81 days for HMO (Health Maintenance Organization) products.

    C. Hand delivering batches of paper claims because of the lack of confidence the electronic claims will be accepted. We recently made a third attempt at getting a batch of claims processed.

    D. During normal business hours the insurance company stops its provider support and goes to an automated attendant which simply states "claims are being processed". Account monitors who were hired to follow up on outstanding claims can only listen to a pre-recorded message.

2. Insurance companies put the burden of patient eligibility determination on the provider. This is an insurance company function. We see claims rejected even when attaching member insurance cards to the claim. Provider overhead is spent chasing down employees who may have changed from one product line to another within the same insurance company. A single eligibility file would be helpful.

3. Insurance companies want a written notice from a provider when a provider must restrict his/her practice due to volume. Yet, the insurance company won't report the addition or deletion of employer groups that affect this patient volume.

4. In a recent insurance company contract negotiation, it was asked if the company might define or provide an example of a "clean" claim. The response, "a clean claim is one we accept and pay on".

5. Providers are requested to file a claim in 90 days. If there is a coordination of benefits issue, you may not be able to file secondary insurance in this time frame.

6. Providers have to continually monitor insurance company payments to insure contracted fees are being paid. Fees change without notice or acceptance.

7. Insurance companies lease provider networks and in these arrangements have difference benefit plans. Providers have little or no recourse with billing and claims issues under these types of arrangements.

8. The squeaky wheel response is the providers best/worst claims settlement option. The provider who continually squeaks gets the most action, but it requires an ongoing effort that most providers can't or shouldn't have to provide on an ongoing basis.

9. There is no uniform insurance company member identification card.

10. Insurance companies promote annual exams which include pap smears. The payment will cover the lab related costs, but not the visit itself which was necessary to obtain the specimen. Payment methodology doesn't seem to be aligned with the right incentives.

Providers want to provide quality patient care, but unfortunately are being asked to focus their attention to cash flow. Increasing debt loads, unpaid bills, the ability to meet payroll, employee turnover, and confused patients have become the norm.

Physicians and their staffs work hard to promote quality patient care and service. It's in everyone's interest to provide quality patient care, but it's not unreasonable to expect insurance companies to pay fairly, accurately, and on time. Physicians should not have to jump through hoops to receive these payments.

We support action that brings resolution to the issues above, and appreciate the interests of this committee to consider these issues and others that have been raised on behalf of physicians.

Senate Committee of Financial Institutions and Insurance
March 8, 2000

Chairman Steffes, members of the committee, I am Darrin Kistler, the administrator for a specialty medical group in the Kansas City metropolitan area. I am here on behalf of the patients we care for, the staff we employ and the physicians I represent.

Cancer is a disease with both physical and emotional implications. Our physicians and staff are well trained to care for the physical aspects of the disease, however the emotional burdens faced by most cancer patients can be overwhelming. The cost of cancer care is stifling. As a former clinician, I often told my patients to focus their energy on getting better not on the financial implications of the treatment. Although it sounded good at the time, it is not a practical solution. These patients have many financial considerations that are compounded by the lack of timely payments by insurance companies. Patients are facing unnecessary months waiting to find out their personal responsibility. These same patients are consistently expressing concerns to us regarding annual deductibles, annual out-of-pocket maximums, and healthcare cafeteria plans. Patients need to know when their claims are paid, how much they will owe and they need to know on a timely basis. This problem is often out of the providers control, yet we are routinely the ones patients come to for answers.

Our practice has strategically expanded our geography to provide services in areas that fitted the needs of our patients and business. We have done our best to deal with the payer community in contractual negotiations but have been unsuccessful. Our group cannot "walk-away" from a payer that generates 10% of our revenues and remain profitable. Isn't it ironic that the two largest commercial insurance companies in Kansas City are the slowest payers for our practice? We need significant legislation passed to level the playing field, if we are going to continue to offer these services to patients.

My practice carried Accounts Receivable (AR) exceeding $3 million into January 1, 2000. Of this, 52% represented claims over 30 days and 38% were claims over 60 days. We have hired additional staff to assist in the follow-up of these past due claims. I can assure you that little or no interest was or will be paid on these claims. As a result we have had to create a

contingency plan, which includes a line of credit and suspension of physician salaries to meet monthly financial obligations. These measures would not be necessary if payers fulfilled their legal obligations as defined in current statutes and the proposed Bills before us today.

The most significant issue facing our current statute (Section 40-2, 126) is that insurers often hide behind the lack of definition of a clean claim. I encourage you to pass SB 600 and to specifically define a clean claim using the existing Medicare definition. Allowing each payer to define a clean claim will lead to continued abuse of the statutes. Electronic claim submission has become a widespread practice. We need to adopt and enforce a standard format for all providers and payers to use.

Monetary penalties for continued abuse of this policy is urgently needed. Examples of common abuses include: One insurance payer consistently denies the receipt of the claim, despite our evidence that the claim was delivered. Often these claims are submitted multiple times and are partially paid. Another well known payer will frequently deny any procedure performed in multiples, however this multiple services are routinely done in our specialty. And yet a third well known company has assigned new provider numbers and returned our claims for re-submission. These tactics are used to delay payment. I fear that without severe financial penalties, payers will continue their abuse of timely payment statutes.

In closing, I applaud the efforts of this committee. I implore you to pass SB 600 with the suggestions I have made concerning clean claims. This legislation is necessary and will help ensure the continued quality of care to our cancer patients.