Approved March 24, 2008
Date

MINUTES OF THE HOUSE INSURANCE AND FINANCIAL INSTITUTIONS COMMITTEE

The meeting was called to order by Chairman Clark Shultz at 3:30 P.M. on March 18, 2008 in Room 527-S of the Capitol.

All members were present except:
Representative Jeff Colyer- excused
Representative Brenda Landwehr- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Bruce Kinzie, Revisor of Statutes Office
Ken Wilke, Revisor of Statutes Office
Sue Fowler, Committee Assistant

Conferees appearing before the committee:
Fred Lucky, Kansas Hospital Association
Holly French, Newman Regional Health
Jean Garten, Olathe Medical Center
Patrick Patterson, HCA, Inc., Midwest Health System
Jim Watson, State Government Affairs
Tim Mergens, United Health Care

Others attending:
See attached list.

Hearing on:
SB 563 **Utilization review organizations requirement for notification of admission, limitation on**

Melissa Calderwood, Legislative Research Department, provided a brief overview on **SB 563**.

Proponents:

Fred Lucky, Kansas Hospital Association, (Attachment #1), presented testimony before the committee in support of **SB 563**.

Holly French, Newman Regional Health, (Attachment #2), gave testimony before the committee in support of **SB 563**.

Jean Garten, Olathe Medical Center, (Attachment #3), appeared before the committee in support of **SB 563**.

Patrick Patterson, HCA, Inc., Midwest Health System, (Attachment #4), presented testimony before the committee in support of **SB 563**.

Dan Morin, Kansas Medical Society, (Attachment #5), presented written testimony in support of **SB 563**.

Opponents:

Jim Watson, State Government Affairs, (Attachment #6), gave testimony before the committee in opposition to **SB 563**.

Tim Mergens MD, United Health Care, (Attachment #7), appeared before the committee in opposition to **SB 563**.

Larrie Ann Lower, Kansas Association of Health Plans, (Attachment #8), presented written testimony in opposition to **SB 563**.

Hearing closed on **SB 563**.

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

MINUTES OF THE House Insurance and Financial Institutions Committee at 3:30 P.M. on March 18, 2008 in Room 527-S of the Capitol.

Discussion and action on:

Sub for 209 Insurance; rate and form filings; error notification procedure

Representative Anthony Brown moved **Sub for 209** favorable for passage and place on Consent Calendar. Seconded by Representative Grant. Motion carried.

SB 443 Long-term care partnership act

Representative Anthony Brown moved **SB 443** favorable for passage and place on Consent Calendar. Seconded by Representative Neighbor. Motion carried.

SB 560 Enacting the property/casualty flex-rating regulatory improvement act

Representive Dillmore moved to adopt the balloon amendment as provided on **SB 560**. Seconded by Representative Kiegerl. Representative Grant made a substitute motion to pass **SB 560** favorable for passage. Seconded by Representative Anthony Brown. Motion carried.

SB 465 Casualty insurance filings for rates and forms

Representative Anthony Brown moved **SB 465** favorable for passage and place on Consent Calendar. Seconded by Representative Grant. Motion carried.

SB 127 Insurance; subsidence insurance

Representative Dillmore moved **SB 127** favorable for passage. Seconded by Representative Grant. Representative Carlson made a substitute motion to table **SB 127**. Seconded by Representative Anthony Brown. Motion failed. A vote was taken and a division called with outcome of 5 in favor and 7 against. Back on original motion. Motion carried.

SB 472 Pooled Money Investment Board; investment in certain corporate bonds

Representative Dillmore moved **SB 472** favorable for passage and place on Consent Calendar. Seconded by Representative Neighbor. Motion carried.

HB 2601 Insurance, reimbursement for certain services

Representative Dillmore made a motion to delete contents of **HB 2601** and insert contents of **HB 2696**. Seconded by Representative Grant. Motion carried. Representative Goico moved **Substitute for HB 2601** favorable for passage. Seconded by Representative Burroughs. Motion carried.

Representative Grant moved without objection to accept the minutes of March 13, 2008.

Next meeting will be Monday, March 24, 2008, 3:30 PM in Room 527-S.

Meeting adjourned.

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

Insurance and Financial Institutions Committee
Guest Sign In Sheet
Tuesday, March 18, 2008

Name	Representing
Jamed Forbes	VHG
Alex Kotoyantz	P.I.A.
Lee Wright	Farmers
David Hanson	KS Insur Assns
Cory Sheedy	KHPA
Bill Sneed	State Farm
Katie Furebaugh	Kearney and Associates
[illegible]	Farmers Alliance

Thomas L. Bell
President

TO: House Insurance and Financial Institutions Committee

FROM: Fred Lucky
Vice President

DATE: March 18, 2008

RE: SB 563 – Notification of Admission

The Kansas Hospital Association appreciates the opportunity to provide testimony in support of Senate Bill 563. This legislation would prohibit a utilization review organization from requiring notification of admission prior to the next business day after a patient presents to a health care facility.

Senate Bill 563 places in statute the industry standard that health insurance carriers will accept inpatient admission notification by the end of the next business day. Requiring hospitals to provide admission notification any sooner, such as within 24 clock hours after actual admission regardless of weekends or holidays, would require hospitals to re-engineer their admissions process, add staff and incur substantial additional costs.

The Kansas Hospital Association has surveyed its members on whether a 24 clock hour admission notification policy would impact their facility. None of those hospitals responding to the survey currently staff in a manner that would allow them to comply with this type of policy, and the vast majority of the members responding indicated that compliance would have a significant negative impact on their operations. Compliance would require the addition of trained staff on weekends and holidays, with skill levels in coding, case management and social work in order to satisfy such notification requirements and to be able to deal with the case management concerns arising from utilization review inquiries that admission notification presumably stimulates.

Hospitals, out of cost constraint necessity, maintain only a skeleton administrative team on weekends and holidays. Therefore, hospitals would not have much of the information requested within the time frame demanded for notification, such as ICD-9 codes or physician tax ID numbers. Extra costs would also have to be incurred by hospitals, in order to hire and train additional staff, and then employ them at higher pay rates for weekend and holiday duty.

The administrative burden necessitated by compliance with a 24 clock hour admission notification policy would unnecessarily contribute to increasing health care costs. The threat of reimbursement

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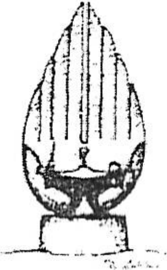
cuts for failure or inability to comply exacerbates that problem. Patients are ultimately impacted by increasing cost pressure on insurance premiums. Patients may also find their access to care restricted if individual hospitals determine they cannot accept patients covered by this type of policy because of an onerous admission protocol. In turn, patients may then find that they will need to seek care out of network, at a significantly higher out-of-pocket cost burden.

It is difficult to see what potential benefit is derived by requiring a 24 clock hour admission notification policy at all – much less, any benefit that outweighs the immediate and substantial burden the protocol will impose on both urban and rural hospitals and the patients they serve. We respectfully request that the House Insurance and Financial Institutions Committee take action on SB 563 to place in statute the industry standard of next business day for admission notification policies.

Thank you for your consideration of our comments.



Lindsborg Community Hospital

605 West Lincoln, Lindsborg, Kansas 67456 • Phone 785-227-3308 • FAX 785-227-4130

March 14, 2008

Dear Distinguished Members of the House Insurance and Financial Institutions Committee:

As leaders of Lindsborg Community Hospital, we thank you for your consideration of our thoughts in support of Senate Bill No. 563. Utilization review is an important aspect of providing quality patient care in our organization. We strive to ensure that the patients we serve receive care in the appropriate setting, whether that be acute care, outpatient, observation, or in the emergency room.

The current staffing structure does not allow for Lindsborg Community Hospital to provide admission notification within 24 clock hours. The time required to provide notification and the knowledge level needed to provide the appropriately related information on the patient's medical condition, could not be met by the limited nursing staff available. The options available to a critical access hospital to implement admission notification within 24 clock hours would be to either add more staff at increased rates of pay for weekends and holidays, or to require current staff to spend less time at the bedside caring for patients. The hiring of additional staff is a difficult task, as the challenge of recruiting well-qualified nurses without increasing expenses, is not possible. Removing current staff from the bedside puts the care and safety of our patients at risk. Rural nursing staff does not have the ability to take on any additional duties, with an already filled 8 or 12 hour shift.

Senate Bill No. 563 is good legislation which addresses the concerns of all parties involved relating to providing quality care in the proper setting and controlling health care costs. All organizations involved in a requirement of admission notification within 24 clock hours should expect to see a rise in health care related salary costs due to weekend and holiday pay differentials. The goal of health care facilities is to work with utilization review organizations to provide quality care at reasonable costs. Admission notification within 24 clock hours does not meet the goal.

Again, we thank you for your time and consideration in support of Senate Bill No. 563.

Sincerely,

Larry Van Der Wege
Chief Executive Officer
Lindsborg Community Hospital

Laraine Gengler
Chief Financial Officer
Lindsborg Community Hospital

Statement to the Insurance and Financial Institutions Committee
On SB 563
The University of Kansas Hospital
March 18, 2008

United Healthcare recently announced a policy that would require administratively burdensome admission notification requirements. From the beginning, the University of Kansas Hospital (KU Hospital) strongly opposed this policy due to its negative financial implications for hospitals.

After United Healthcare indicated that this policy was not subject to change or negotiation, KU Hospital volunteered to be part of a pilot group, which would attempt to develop a business process to minimize the administrative burden and financial risk of the hospitals. KU Hospital's participation in the United Healthcare pilot program pertaining to admission notification should not be construed as support for UHC's unilateral policy announcement.

Further, KU Hospital's participation as a pilot member has not yielded the desired results. KU Hospital fully supports the position of the Kansas Hospital Association and the efforts of the Kansas Legislature via SB 563 to prohibit a utilization review organization from requiring notification of admission prior to the next business day and imposing financial penalties for failure to comply.

saintlukeshealthsystem.org

March 18, 2008

TO: House Insurance and Financial Institutions

FROM: Rich Hastings, CEO, Saint Luke's Health System
Julie Quirin, CEO, Saint Luke's South Hospital
Ron Baker, CEO, Cushing Memorial Hospital
Denny Hachenberg, CEO, Anderson County Hospital

RE: Senate Bill 563 – Notification of Admission

We appreciate the opportunity to provide comments supporting SB 563. We are in agreement with the testimony provided by the Kansas Hospital Association, and respectfully request this committee take favorable action on this bill.

KHA has surveyed its members to determine how a "24 clock hour" admission policy will effect their operations, and they have submitted to you information on the impacts anticipated by the hospitals in Kansas if this legislation is not passed. At Saint Luke's Health System, we have also evaluated the potential impacts if SB 563 is not passed. The results of our analysis have shown that for our health system alone, we project an annual increase in staffing cost of $277,000 for trained admitting staff, not including hospital case managers. These costs are based on the additional personnel necessary to comply with only one utilization review organization's request that we provide notification to them within 24 hours of patient admission. It is important to consider the nature of patient admissions. Often, patients are not immediately admitted as an inpatient. Instead, they are admitted for observation to determine the best course of action. If, during the observation period, it is determined that a patient requires inpatient admission, the "24 clock hour" notification as requested by these utilization review organizations can start when the patient visit was initiated, not when the decision to convert this patient to an inpatient is made. As a result, we will need to have case managers available 24 hours a day, 7 days a week that can assist in fulfilling this request. It is not standard practice to have this level of staff at the hospital on weekends and holidays. What's more, we fully anticipate more utilization review organizations will duplicate these requirements if this bill is not enacted, further increasing the cost of compliance. As a result, the administrative cost to provide health care will increase, yet the patient will not receive any additional health care.

If placed into statute, SB 563 will prohibit utilization review organizations from requiring notification of admission prior to the next business day after a patient presents to a hospital. It is current industry standard for next business day notification of admission, and we are asking for that standard to be maintained. Hospitals are already inundated with administrative rules that have little or nothing to do with providing quality care to our patients, and we respectfully ask you to pass this legislation to prevent one more administrative burden from being added.

March 18, 2008

To: The House Insurance and financial Institutions Committee Members
From: Samuel H. Turner, Sr. President and CEO, Shawnee Mission Medical Center

Dear Chairman Shultz,

On behalf of Shawnee Mission Medical Center I ask for your committee's support in passing SB 593 favorably. This bill as passed by the Senate represents a balance between effective and efficient administrative procedures and preservation of best practice when serving the patients from our community.

For over four decades, Shawnee Medical Shawnee Mission Medical Center has been committed to high standards of community care. SMMC's 54-acre campus includes a 383-bed hospital, a free-standing outpatient surgery, a community health education building, five physician office buildings and an associate child care center. As more patients base their hospital choice on the quality of care they expect to receive, more people – from our community and throughout the region – are making SMMC their destination of choice for health care excellence.

Our support of SB 563 is compatible with our sense of mission and community commitment. As you are aware this bill would prohibit a utilization review organization from requiring notification of admission prior to the next business day after a patient presents to a health care facility. There is no evidence that a change in the current "next day industry standard" would improve quality of care to patients or create an administrative benefit. In fact requiring a stricter reporting standard would only increase administrative costs. In an environment that is sensitive to ever increasing health care costs we too scrutinize those administrative efforts that create additional burden without additional benefit to patient care. This bill would provide necessary safeguards against needless modifications in administrative procedures and would maintain a practical industry standard.

We thank you for your consideration of our comments. If you have any further questions please don't hesitate to contact Melissa Ness our legislative liaison. She can be reached at mlness@connections-unlimited.net or 785-554-8864.

Copy to: Representative Brown, Dillmore, Carlson, Colyer, Goico, Holmes, Humerickhouse, Kiegerl, Landwehr, Masterson, Peck, Burroughs, Faust-Goudeau, Grant, Neighbor, Wetta

March 18, 2008

House Insurance and Financial Institutions Committee

Dear Representative Clark Shultz and Committee Members:

This letter is in support of SB 563, which relates to prior authorizations for hospital admissions. This bill is very important to Menorah Medical Center.

SB 563 would prohibit utilization review organizations from requiring notification of admissions prior to the next business day, such as within 24 clock hours after the actual admission – regardless of weekends or holidays. Without this legislation, some insurance companies would put undue and unrealistic burdens on hospitals.

SB 563 would maintain the industry standard of "next business day" for completion of the authorization process. Attempting to complete authorizations over the weekends would be very difficult and costly to hospitals. Trained staff is not available on weekends and holidays. To re-design the process would require additional staff and would add cost. There's no evidence or assurances that the information obtained would even be used for case management until the next business day.

Please support and take action to approve SB 563.

Sincerely,

Steven D. Wilkinson
President & CEO

For your whole life™

March 18, 2008

TO: House Committee on Insurance and Financial Institutions

FROM: Holly French
Chief Financial Officer
Newman Regional Health

RE: Senate Bill 563 – Notification of Admission

I appreciate the opportunity to speak in favor of Senate Bill 563 which would prohibit a utilization review organization from requiring notification of admission prior to the next business day after a patient presents to a health care facility.

Newman Regional Health is a Sole Community Hospital. The staff that is responsible for providing the notification to utilization review organizations is minimal even during the business week. We do not staff any of these administrative positions outside of the normal business day. To require this of an organization our size would be cost prohibitive.

We have been told by these utilization review organizations of ways that we can submit this information to them on a 24/7 basis. This does not change the fact that we must have the staff available at all times to provide technical information such as ICD-9 codes and physician tax identification numbers among other items required. This requires specialized staff to provide this information. These positions, especially qualified coding staff, are not easily recruited. This will again increase the cost to care for our patients and is an administrative burden required by these utilization review organizations with no perceived benefit.

We must weigh the increase in cost to provide the necessary staffing versus the loss of potential reimbursement to our facility. This may necessitate contract cancellations with these organizations due to the negative cost benefit analysis. This will impact our patients significantly by increasing the cost of healthcare. Patients will be forced to pay increased costs for out of network care. This is not something that we as a hospital provider take lightly. We know this will impact our patients and our community employers. We therefore make every effort to prevent this and that is why I am here today.

Providers struggle now to cover the cost of healthcare with the continuing reductions to reimbursement. We cannot afford to lose additional reimbursement for care that we provided in good faith to our patients.

Any admission that is done on nights, weekends, or holidays, is done only because it cannot be delayed. Physicians are very busy people and especially during these times would not admit patients without a very real need. This is an inconvenience to our physicians and to our patients and is avoided if at all possible.

It is difficult to understand how this notification will provide any benefit. In fact, we question whether these organizations will have the staff available to do anything substantive with this notification. I do very clearly understand the impact of requiring the notification: 1) decreased reimbursement to providers, 2) increased cost of caring for our patients, 3) increased cost to our patients.

I do hope the House Committee on Insurance and Financial Institutions will place in statute the industry standard of next business day for admission notification policies. Your decision will impact not only rural communities and providers but healthcare in general. Thank you for your time and consideration of this issue.

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

Date:	**March 18, 2008**
To:	**Kansas House Financial Institutions and Insurance Committee**
From:	**Jean Garten, FACHE**
	Olathe Medical Center
	Vice President - Health Access Inc.
	Vice President - Olathe Medical Center Charitable Foundation
Re:	**SB 563 – Notification of Admission**

Good afternoon. It is my pleasure to speak to you today on behalf of SB 563. My name is Jean Garten. I am employed by the Olathe Medical Center. I am Vice President of the Olathe Medical Center Charitable Foundation in addition to other responsibilities related to managed care contracting. In that capacity, I am Vice President of Health Access, a Provider Sponsored Organization, which contracts for 7 hospitals and 1,200 physicians in the KC area. I also oversee the managed care contracting specific to the Olathe Health System facilities and physician clinics. It is in the later 2 capacities that I come to you to share our support for the amendment language proposed by the Kansas Hospital Association for SB 563.

SB 563 would prevent organizations that conduct utilization review from requiring hospitals to provide admission notification on a 24 hour, 7-day a week basis. Rather it would maintain the industry standard of providing notice by "next business day". Olathe Medical Center and other Health Access Hospitals are not staffed to provide round the clock notifications without substantial costs in increased labor and higher shift differentials due to required staffing on weekends and holidays. Given hospitals are already overburdened with administrative rules that have little to do with providing efficient and quality care to patients, this additional administrative requirement is unwarranted. In fact it has been our experience that these administrative notification requirements are used in a way to deny or delay payment, as opposed to direct or authorize care. There is no evidence or assurances that information of the nature requested by these organizations on weekends and holidays is even used for case management until the next business day in any event.

Obviously the language proposed by KHA will hold the utilization review organizations at their current status in denying claims, but it will not take care of the issues we are experiencing with some carriers presently in regard to administrative denials or late filing of claims for those patients that do not have their insurance information with them at the time of service. Let me explain:

By allowing an insurance company to deny payment based on notification and or timely billing (when the hospital has no control over a patient providing insurance identification at the time of service) puts the hospital in a very vulnerable position.

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Some carriers use this penalty on a regular basis regardless of whether or not a patient is admitted through the emergency room or directly for observation or medical treatment. Although we are obligated to provide care, the insurance company, after the fact, uses this clause to deny payment. Presently, I am appealing 11 claims with a specific insurance company dating back to June 2006, in which they have administratively denied payment based on this notification requirement. Out of the 11 claims, and many hours of copying records, sending appeals, 1 claim has been overturned. In all 11 cases, it would appear that either the patient did not have insurance information at the time of service or provided the wrong information. In at least 2 cases, it was uncertain at the time of admission whether or not the insurance company was primary to Medicare or not. In some cases, it would appear that we were told by the company that we did have a pre-cert, only later to be told that we did not. In one case, it was an incorrect status that led to our lack of pre-cert. Although we continue to fight on these remaining 10 claims, the denials continue to accumulate. It will be an ever-challenging battle to get paid.

We have an opportunity to make a statement with SB 563 or future legislation. The statement that we will no longer tolerate unfair treatment. When a hospital provides medically necessary services in good faith without the benefit of knowing who the payor is at the time of service, the insurer should be obligated to pay for the services regardless of when the hospital/provider is able to notify the payor.

The insurance company will claim that without a penalty, hospitals will not notify the insurance carrier. As such, the hospitals do everything they can to get the bills out and paid in a timely manner. The fact the hospital bills the insurance company later (after discharge) delays payment and is penalty enough. In some cases, the insurance companies have further penalties if a claim is not filed in a timely manner from the date of service. Again, if the information is not readily available at the time of service, it may be months before the provider has the information for billing the appropriate payor.

Insurance companies will state that they must have notification for case management. As such, they are already aware of any chronic disease processes based on the claims data in their systems. In regard to acute admissions, the Insurance companies should be challenged to document situations in which they have been prohibited from any meaningful case management due to a change in this notification process.

In reality, if a hospital has the insurance information at the time of admission, it will notify the carrier. If the member does not have the information at the time of service, is it ethical or fair for the insurance company to deny payment to the provider of services? In particular when the provider is prohibited from billing the patient for covered services. May I reiterate, this leaves the hospital in a very vulnerable position at a time when hospitals are already struggling to provide charity and uncompensated care at increasing levels. In contrast, the insurance companies have already collected premiums from the member in amounts expected to cover the costs of services. In essence, this denied payment goes directly to their bottom line. I ask you again, does that sound like a fair system?

Thank you again for taking the time to listen to this testimony. Your support of SB 563 and consideration of future legislation addressing denials based strictly on administrative notice is appreciated.

HCA

Midwest Division

House Insurance and Financial Institutions Committee
Testimony re: SB-563
Presented by Patrick L. Patterson
on behalf of HCA, Inc.
March 18, 2008

Mr. Chairman, Members of the Committee:

My name is Patrick Patterson, and I am Vice President of Managed Care for the HCA Midwest Health System. HCA, Inc. is the nation's leading provider of healthcare services, composed of locally-managed facilities that include over 180 hospitals and nearly 100 ambulatory surgery centers, and employing approximately 1200 physicians. HCA is concerned about all issues relating to the healthcare industry.

HCA supports SB-563, which would prohibit health insurers from implementing admission notification requirements that are unreasonable – i.e., that are inconsistent with industry standards, are unduly burdensome to healthcare providers and do not add value to the healthcare delivery equation. More specifically in this regard:

* One (and only one) healthplan recently attempted to promulgate a new admission notification policy that would require healthcare providers to notify it within 24 hours of an admission – including weekends and holidays, and irrespective of whether the admission was emergent in nature.

* When this policy announcement was made, several other healthplans with which we do business called me to both (a) reassure me that they did not intend to follow suit, and (b) express their hope that we would strongly oppose it. Indeed, those healthplans shared our view that such a policy was unreasonable – yet at the same time, they were concerned that any healthplan successful in getting away with such a strategy would put competitive pressure on them to adopt similar policies.

* The current (and reasonable) industry standard for admission notification is one by which all healthplans abide, and with which hospitals have adapted their systems to comply. This is that a hospital is required to notify the healthplan of an admission the later of: (a) within 24 hours after the admission; or (b) the next business day. It serves to ensure a "level playing field" by standardizing the "rules of engagement" for all involved in the process.

* It also serves to fairly protect hospitals from potentially abusive healthplan policies that, if left unchecked, could be deployed so as to act as a mere excuse to simply not pay a healthcare provider for legitimate care (i.e., medically necessary services that are supposedly covered under a subscriber's health insurance policy, and for which a premium has been collected by the healthplan).

Historically, this "gentlemen's agreement" regarding notification protocols has served both the healthplans and the healthcare providers equitably. In turn, no regulatory protection has been necessary in this regard heretofore. But because of the out-of-bounds efforts of a single healthplan, it is now necessary to regulate these sorts of practices.

HCA Midwest Health System • 903 East 104th Street, 5th Floor • Kansas City, Missouri 64131 • (816) 508-4060

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Currently, hospitals are simply not in a position to be able to provide admission notifications on a 24/7 basis, nor is it reasonable to expect them to do so. It would cost each Kansas hospital at least one additional FTE (perhaps more) to be able to satisfy such a stringent notification requirement. Yet this resource would be expended solely to report on what occurred relative to a patient, and not one penny would actually go toward enhancing the care of the patient. In an era of spiraling healthcare costs and a growth in the number of uninsureds, the last thing the healthcare industry needs to be doing is to be needlessly spending money in order to protect against the risk of unfair healthplan denial practices.

Finally, the HCA hospitals have a form of electronic health record that can be accessed remotely by healthplans on a 24/7 basis – including weekends and holidays. When we offered this "access solution" to the healthplan in question in lieu of our hospitals having to add staff in order to accommodate the healthplan's new notification requirements, the healthplan told us "thanks but no thanks, you have to notify us of the admission in precisely the manner that we are directing you to notify us".

That our reasonable suggestion was flat-out rejected told us that this healthplan didn't really care about the information that it was asking for after all – and, ironically (but not surprisingly), the healthplan wasn't interested in spending its own resources to match what it was expecting the hospitals to expend. Instead, what this told us was that the healthplan was merely searching for a novel way to avoid paying healthcare providers by trying to force upon them a new "gotcha!" policy that the healthplan knew could not be complied with by most hospitals.

The bottom line is that while programs such as this serve to drive up healthcare costs, they add no value whatsoever to the healthcare delivery equation. In turn, and because healthplans may not have the ability to control themselves in their own policy-making arena, such practices need to be statutorily prohibited – in this particular case, in the form of passage of SB-563.

Thank you very much for permitting me to testify, and I will be happy to yield to questions.

Patrick L. Patterson
Vice President, Managed Care
HCA Midwest Health System

Kansas Hospitals Represented:	Allen County Hospital – Iola, Kansas Menorah Medical Center – Overland Park, Kansas Overland Park Regional Medical Center – Overland Park, Kansas Wesley Medical Center – Wichita, Kansas
Other Kansas Healthcare Facilities Represented:	Mid-America Surgery Institute – Overland Park, Kansas Overland Park Surgery Center – Overland Park, Kansas Surgi-Care of Wichita – Wichita, Kansas Surgicenter of Johnson County – Overland Park, Kansas Wesley Cardiovascular Services & Cath Lab – Wichita, Kansas

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www.KMSonline.org

To: House Committee on Insurance and Financial Institutions

Fm: Dan Morin
Director of Government Affairs

Subject: SB 563; AN ACT concerning health insurance; pertaining to utilization review

Date: March 17, 2008

The Kansas Medical Society appreciates the opportunity to submit comments in support of SB 563, which would amend a statute governing utilization review organizations to create an admissions standard and prohibit prohibited from requiring notification sooner than the next business day after any inpatient admission occurring on the weekends or holidays or any urgent or emergent inpatient or outpatient admission.

Currently, when a patient is admitted to a hospital, the admitting physician supplies the hospital with an admitting diagnosis. It's usually just the description (e.g., chest pain), not the specific ICD-9 codes. Without SB 563, if a carrier wants to start a utilization review on the patient, then the nurse (or staff) at the hospital will have to communicate with the physician to determine the treatment plan, expected length of stay, etc. KMS believes this is where the physician, and extended provider staff within a hospital, would be diverted away from direct patient care and instead assume a more administrative role to document extensive non-clinical information due to reduced administrative staff available during weekends and holidays.

Thank you for the opportunity to offer these comments.

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UnitedHealth Group

James S. Watson, Vice President, State Affairs
8101 "O" Street
Lincoln, Nebraska 68510
Tel (402) 327-2446 Fax (402) 327-2453

Testimony in Opposition to SB 563
Kansas House of Representatives
Insurance and Financial Institutions Committee
Tuesday, March 18, 2008

UnitedHealth Group respectfully offers the following testimony in opposition to SB 563:

Throughout the 1990s, health insurance companies covered medical care and procedures so long as they were "medically necessary". Physicians and facilities were required to submit records to justify their planned care. Of course this "managed care" created inevitable conflict as insurance companies came between customers and their physicians.

In 1999, after looking carefully at its care management programs, UnitedHealthcare realized that we were spending our resources to determine medical necessity, and most of the time we were saying "yes". In November of that year, United dramatically changed its philosophy of care management to no longer require that care be medically necessary in order to provide coverage. In fact, UnitedHealthcare does not insist upon prior authorization for a hospitalization, nor do we assign a length of stay.

Instead, we ask our national network of physicians and facilities to notify us of certain events as required in their contract with us. When we are notified we begin to identify what we can do to improve the effective and timely delivery of services. Dr. Mergens, who will testify following me, will elaborate.

A new notification program we introduced last fall contractually obligates hospitals to notify us within 24 hours **following** an admission. In the original roll out of this program, the 24- hour notification program was to be in place seven days a week. However, we heard from hospitals that this may be challenging so we ARE CURRENTLY NOT imposing the seven day a week notification program

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pending the results of a pilot program. The pilot program was established in response to the issues raised by hospitals and will aid UnitedHealthcare in determining whether we can successfully extend the notification requirement to weekends as well.

Here's why weekend notification is important. A hospital's doors are open 7 days of the week. In fact, 30+% of our admissions occur Friday through Sunday. In most cases, our care coordination nurses can not engage these weekend admissions in the care coordination process until Monday or Tuesday, i.e. next business day. Given that our average-length-of stay is 4.0 days, most Friday thru Sunday admitted patients do not benefit from our care coordination services or do not access them in a timely manner. We would like to offer supportive care coordination 7 days of the week on a nationwide basis.

The pilot began in January of this year. UnitedHealthcare engaged nearly 150 representatives from over 300 hospitals for their feedback on the 24 hour admission notification requirement. We next invited both large and small hospitals as well as urban and rural facilities to participate in the pilot program, which began with 3 workshop meetings in Atlanta, St. Louis and Phoenix during the last week of January and the first week of February. UnitedHealthcare covered travel and hotel accommodations for all participants.

Pilot participants were able to select their preferred method of notification. There are several ways a hospital facility can provide notification: 1) Unitedhealthcareonline.com 2) EDI (electronic 278 claim) transaction 3) telephone 4) VoiceCert 5) facsimile or facsimile of the hospital's UHC daily census logs 6) direct access by UHC to the hospital administrative system.

Pilot participants have now been asked to follow the 24 hour notification requirement during two test phases of approximately 3 weeks each. Testing feedback is being collected via a standard tracker, with analysis and recommendations being shared through Web Conferences hosted by UnitedHealthcare.

The testing, feedback and analysis phases will run through late May to early June, and the results will determine whether UnitedHealthcare will move forward on July 1, 2008 with the 24 hour notification requirement for its national network of facilities.

In closing, we want our members/insureds, who are admitted to hospitals on the weekend, to benefit from the same care coordination our members receive Monday through Friday without delay and this can only be accomplished if we are notified that one of our member/insureds has been admitted. The results of the pilot program will help United determine the best practice for notification, which will provide our members – the patient – all of benefits of care management to which they are entitled.

Therefore, we submit to the committee that SB 563 is premature and not in the best interest of the patient. It ignores the fact that patients entering a hospital on the weekend should receive the same benefits as if they were admitted during the week. We respectfully request that the committee not advance this bill.

UnitedHealth Group

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Testimony in Opposition to SB 563

UnitedHealthcare seeks to improve the health and safety of its members as they move through the health care system. Recognized some ten years ago by the Institute of Medicine in its publication "To Err is Human", a fundamental barrier to improved outcomes relates to the fragmentation of care, particularly the fragmentation that occurs with transitions of care. In fact continuity and coordination of care is so important a function for a health plan, that our accrediting body, the National Committee for Quality Assurance (NCQA) defines a specific standard just for that purpose. This system fragmentation is a major driver of poor healthcare outcomes. Recently, the Centers for Disease Control and Prevention estimated that 270 individuals die in our country each day as a result of hospital acquired infections. Research also shows that the risk of hospital acquired infections increases by 6% for every day a patient is hospitalized.

UnitedHealthcare utilizes nationally established guidelines of care to target specific conditions and procedures that are most likely to experience complexities and we use those guidelines to partner with doctors, nurses and hospital staff to ensure that the proper timeliness and sequencing of care occurs for our members. We track the care provided, looking for specific milestones. We want to know that when a physician orders a test or treatment, that it is delivered promptly, without delay. We want to assist hospital staff by eliminating barriers to discharge. We do this by staffing care coordination nurses seven days per week to assist hospital discharge planners in arranging aftercare.

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Our various care coordination activities are all specifically targeted based on internal data and the peer reviewed literature. Using this information we have been able to substantially reduce the number of conditions and procedures for which we require advance notification. We are also able to specifically target for outreach certain members after hospital discharge to ensure that the discharge plan is meeting their needs, and if not to alert their physician. These activies are shown to reduce readmissions by 40%.

In summary, a fundamental breakdown in American healthcare today, beyond the uninsured issue itself, is fragmentation in care. Significant work is underway to address various root causes. Health plans like UnitedHealthcare are in a unique position to identify and address fragmentation and gaps in care which leads to significant improvements in health outcomes. Patient safety should be our number one concern. Seven day a week care supports patient safety.

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Written testimony before the House Insurance and Financial Institutions Committee

SB 563

Kansas Association of Health Plans

March 18, 2008

Mister Chair and members of the Committee. Thank you for allowing me to submit written testimony 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 other entities that are associated with managed care. KAHP members serve most all Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comment on SB 563.

The KAHP is opposed to SB 563. We believe this bill is premature and would ask that the legislature delay consideration of the issue until United and participating hospitals conclude the pilot project currently in process. Although no members companies are currently requiring hospitals to notify insurance companies within 24 hours of admission of a patient, some do require notification prior to outpatient procedures being performed. The proponents of the bill agreed to amend the original bill clarifying this issue, however they also added an amendment on lines 36-39 that we feel is unnecessary, too broad and would restrict plans from taking action in all instances of violations of utilization review requirements.

Again thank you for allowing us to testify and I'll be happy to answer any questions you may have.