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SUBCOMMITTEE HEARING ON ENSURING PROMPT PAYMENT FOR SMALL HEALTH CARE PROVIDERS

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SUBCOMMITTEE HEARING ON ENSURING PROMPT PAYMENT FOR SMALL HEALTH CARE PROVIDERS

Wednesday, August 1, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
SUBCOMMITTEE ON REGULATIONS, HEALTH CARE & TRADE
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2360 Rayburn House Office Building, Hon. Charles González [Chairman of the Subcommittee] presiding.

Present: Representatives González, Larsen, Altmire, Shuler, and Westmoreland.

OPENING STATEMENT OF CHAIRMAN GONZÁLEZ

Chairman GONZÁLEZ. The Subcommittee on Regulation, Health Care and Trade on Small Business will come to order. Today's hearing is on ensuring prompt payment for small health care providers.

I am going to begin with an opening statement, but I do want to preface my remarks as well as the remarks by the ranking member, thanking each and every one of the witnesses. Please understand this is probably the busiest time of the session for Members of Congress because we are supposed to go on the August recess and we are trying to do a few things before we leave either Saturday or Sunday or it could be Monday or Tuesday. We are not sure. But we are hoping certain Members will come through.

Also understand you have submitted written testimony and that testimony is actually reference material for us. And the questions that we will be posing today will again inform us, enlighten us and guide us. And staff is here, of course, and we count on them to take a lot of notes but we do that ourselves. Again, thank you very much. And I am hoping we will have members—as a matter of fact, we have been joined by Congressman Shuler at this time. Members may come in and out, and that is just the nature of the beast around here because there are so many demands being made on Members. And the Chair will recognize himself for an opening statement.

Small physician groups face many challenges today. Unfortunately, many of these have nothing to do with practicing medicine. Whether it be the increase in bureaucracy of managed care or the prospect of reduced Medicare reimbursements, it can be extremely difficult to make these businesses profitable.

Today's hearing will look at one of the biggest financial challenges facing the industry. Payments from insurance companies to health care providers have long been a concern of health care providers and their member organizations. Providers have shown that some insurers delay payments for a significant portion of the insurance claims. This often leads to cash-flow problems and increases the cost of care for the patients that they serve.

Such conditions are particularly problematic for small health care providers. As small businesses, they just cannot afford to be exposed to the sort of instability that an unpredictable revenue stream creates. Payment delays are nothing more than an unfair business practice that let insurance companies earn interest on money owed. Cash flow is an important issue for the small practice and late payments hinder their ability to run and expand their businesses.

The insurance community argues that the prompt payment of claims is not a problem, that the market in concert with State laws will address any lingering problems. This subcommittee is interested in our witnesses' responses to that particular assertion. Small providers lack the financial resources to hold insurance companies accountable for their failure to make timely claim payments. If an insurer is unwilling to make a payment or wants to delay payment, what remedy do small practices have at hand to compel payment unless we provide them with one? Only prompt payment laws that are enforced make it possible for small providers to be paid in a timely and fair manner.

Efforts to enact prompt State payment laws have been successful. To date, all 50 States and the District of Columbia have prompt payment rules that apply to insurers. These laws were designed to help small providers who lack the ability to negotiate payment schedules with insurers or to compel payment. As such, small business health providers can rely on State efforts as opposed to hiring their own attorneys to enforce these requirements.

But there is a problem. States do not seem to be effectively cracking down on insurers who are not complying with State prompt pay laws. In part, the focus of today's hearing is to understand why prompt pay laws fail to be as successful as providers once hoped. Ultimately, health care providers need prompt payment laws that are meaningful in practice, not just on paper. I believe this means promoting stricter enforcement of existing laws, strengthening prompt payment requirements and holding more health plans accountable.

Though prompt payment laws can be found throughout the country, providers seem to uniformly agree that they are far from effective. This is a significant source of frustration for State insurance commissioners who have directed considerable resources to enforcing compliance and providers who are challenged by the problem daily. Without a solution, small practices will continue to struggle.

I would like to thank again each witness. We look forward to your testimony. And at this time I am going to go and yield and recognize the ranking member, Congressman Westmoreland, for an opening statement.

OPENING STATEMENT OF MR. WESTMORELAND

Mr. WESTMORELAND. Thank you, Mr. Chairman , for holding this hearing today. This is a very important hearing, especially for the medical profession. I would also like to thank all the witnesses for your participation. And I am sure that today's testimony will prove to be very helpful to this committee and to our Congress.

Payment for service is the core of our economic system. No industry would survive if those who bought a product only paid a fraction of what it cost. But that is exactly what is happening to physicians in our health care industry. And not only are physicians often paid less than what their services cost, they are also being paid well after the bill comes due. So not only do you not get all your money, you don't get it in a timely fashion. The ironically named prompt payment issue is one that is affecting physicians and patients all over the country. Surveys have shown that it is at the forefront of physicians' concerns and I know that from listening to many physicians that come into our office every day to complain about the system. And their payment schedule is one of the things that they complain the most about.

I don't know about any of you, but when I visit my doctor, I want his full attention to be on what he is doing and not wondering if he is going to get paid for seeing me. Almost every State has enacted some form of prompt payment law in an effort to address this very real issue. Unfortunately, these laws usually have very little enforcement and therefore allow the problem to persist.

I am proud that my home State of Georgia has one of the most comprehensive laws governing payment for medical services. Our law requires that insurers pay claims within 15 working days of receipt. While this law has helped, it has by no means eliminated the insurance companies' desire to withhold payment.

This Congress faces a great challenge as it tries to lower the overall cost of health care, while also providing access to those who need it. I hope that we can all agree that shortchanging our physicians is counterintuitive to having an effective health care system. I know that today's hearings will be helpful in addressing this challenge.

And again I want to thank the Chairman for having the hearing. And I welcome this distinguished panel, and thank all of you for your willingness to testify today. Thank you.

Chairman GONZÁLEZ. Thank you very much. Is there anyone else who wishes to make an opening statement? I want to welcome Dr. Rob Merrill. It says on our agenda that he is representing the orthodontists which are based in St. Louis, Missouri. But I want the record to be very clear that Rob is a citizen-resident of the great State of Washington with Nancy Washington. I have known him and his family for a long time, 10 to 15 years I guess it must be by now. So I really appreciate the hearing, but I wanted to especially welcome Dr. Merrill to the hearing.

Thank you very much. We will proceed with the testimony. I would advise the witnesses that you have 5 minutes, and I know that may not be sufficient time, but we will try to hold you to the 5 minutes. But also understand we will have follow-up questions. And since we don't have as many members present, we are going to have a little bit more time and you will be able to again probably

supplement some of the comments you wish you had covered during your testimony.

The first witness will be the testimony of Dr. Cecil B. Wilson. He is the immediate past chair for the Board of Trustees for the American Medical Association and has been on the Board of Delegates since 1992. The AMA is the largest medical association in the United States. Dr. Wilson has been in private practice of internal medicine in central Florida for 30 years. Dr. Wilson.

STATEMENT OF DR. CECIL B. WILSON, M.D., BOARD CERTIFIED INTERNIST, IMMEDIATE PAST CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. WILSON. Thank you, Chairman González, Ranking Member Westmoreland, and members of the subcommittee for the opportunity to testify today. My name is Cecil Wilson. I am the immediate past Chair of the Board of Trustees for the American Medical Association. I am also an internist from Winter Park, Florida.

The focus of today's hearing is of great importance to the medical community given that 52 percent of physician practices in this country have three or less physicians and account for 80 percent of outpatient visits. Small physician practices have limited leverage relative to large insurance companies since antitrust laws prevent physicians as a group from addressing payment and other contract terms on a level playing field. The ability of physicians to address unfair payment practices continues to diminish with the increasing consolidation of health insurers.

In the majority of metropolitan statistical areas, a single health insurer dominates the market. The growing disparity in negotiating positions has created an environment where insurers are able to evade prompt payment laws with little, if any, adverse consequence. This has a financially debilitating effect on small physician practices and could limit patient access. When one side has all the market power, more efficient market mechanisms are hampered.

A common problem confronted by many physicians is insurers paying claims late. Even if a claim includes all the appropriate information, insurance companies often find reasons to delay or deny payment. This is tantamount to small physician practices extending interest free loans to large insurance companies.

In addition, this seemingly intentional behavior by the insurer creates an onerous administrative burden. Physicians and their staff must spend hours on the phone pursuing payment of unpaid claims. In fact, growing numbers of physician practices have been forced to hire office staff dedicated solely to collecting late payments. Because of this, some have had to eliminate services and clinical staff positions as well as forego equipment upgrades and the adoption of health information technology.

Fundamental fairness warrants timely payment. As the Chair has stated, in 50 States and the District of Columbia, legislation and regulations have been passed tied to the prompt payment of claims. Despite this, physicians still experience problems with receiving payments from health plans in a timely manner. Evidence of the continuing problem is that State regulators have imposed more than $76 million, including fines, interest, restitution and

statutory penalty fees against third-party payors for late payments to physicians and other health care providers.

And it is not just State regulators who have understood the problem. In 2000, a number of individual and class action lawsuits were consolidated and eventually certified to cover more than 600,000 physicians. The suits were brought to address violations of prompt pay laws as well as other payment violations by some of the Nation's largest for-profit health plans. Settlements were reached with most of the insurers.

However, these short-term solutions will begin to sunset this year. The AMA urges Congress to pass legislation that will establish a strong Federal prompt pay standard, protect more robust prompt pay State laws by ensuring the Federal standard is the floor, establish concurrent jurisdiction over enforcement between the State and Federal Government, clarify that State prompt payment laws apply to all ERISA-covered health plans, strengthen penalties to prevent plans from considering fines and other associated financial sanctions as merely the cost of doing business, protect physicians from retaliation by insurers if they pursue their remedies under the prompt pay laws and expand protections to address other tactics utilized by health insurers to delay or decrease payments.

The AMA looks forward to working with the committee to achieve our shared goals of strengthening and safeguarding the viability of small physician practices and providing quality care to patients.

Thank you for the opportunity to be here today.

[The prepared statement of Dr. Wilson may be found in the Appendix on page 24.]

Chairman GONZÁLEZ. Dr. Wilson, thank you very much for your testimony. The next witness is Dr. Rob Merrill. Dr. Merrill is Chairman of the American Association Orthodontist Committee on Governmental Affairs. He is a board certified orthodontist and has been in practice since 1990. The AAO comprises 15,000 members in the United States, Canada and abroad.

Dr. Merrill.

STATEMENT OF DR. ROBERT MERRILL, D.D.S., M.S., BOARD CERTIFIED ORTHODONTIST, CHAIRMAN, COMMITTEE ON GOVERNMENT AFFAIRS, AMERICAN ASSOCIATION OF ORTHODONTISTS, ST. LOUIS, MISSOURI

Dr. MERRILL. Chairman González, Ranking Member Westmoreland, and distinguished members of the subcommittee, on behalf of the American Association of Orthodontists, I thank you for your leadership in holding this important hearing to address issues related to late payment and benefits by insurers. As the current Chairman of the Association's Counsel on Government Affairs, it is my honor to have the opportunity to share the experiences and perspectives of its member orthodontists as the committee considers ways to alleviate the problems caused by the late payment of benefits.

Orthodontists are uniquely qualified and educated dental specialists who correct improperly aligned teeth and jaws. There are cur-

rently 9,200 actively practicing U.S. members of the AAO. Orthodontics is one of America's finest examples of a thriving small business community. The Nation's orthodontists, over 75 percent of whom are solo practitioners that employ an average of seven dental service professionals, currently provide care to an estimated 4.4 million adolescents and 1 million adults. Just over 60 percent of patients nationwide have insurance coverage that includes an orthodontic benefit to one degree or another. In my own office, approximately 55 percent of our patients have orthodontic insurance benefits. The best insurance companies pay claims within 30 days, not unlike the best patients who are also prompt in paying their bills, so we don't have to send out multiple statements requesting payment.

The average orthodontic practice is often hard hit by economic downturns as families often defer what may be perceived as elective orthodontic treatment. Often underscoring these financial difficulties is the practice of insurance companies that delay payments to orthodontic practices and thus cause additional hardship for the practice and its patients.

As health care providers, orthodontists care about the quality of treatment of their patients and have a personal interest in the success of treatment. Since there are a relatively small number of orthodontists nationwide, we believe it is likely that insurance companies view the practices as lightweights that can be moved to the back of the line when it comes to payment of benefits. In short, this issue is about fairness as it involves large powerful insurance companies and their relationship to small community based health care providers and their patients.

I would like to describe five ways in which late payment of benefits by insurers specifically harms the average orthodontic practice, a system used by one insurer that works well in my practice and outlines several areas where legislation could potentially help.

One, cash flow problems. As small businesses, it is important to keep a steady and consistent cash flow in order to pay salaries of employers, the employees, vendors, and to upgrade equipment in order to provide the best, most technologically advanced care to patients. Late payments by insurers complicate cash flow, thus causing numerous accounting problems that require additional time, resources and staff to alleviate.

Two, increased burden on patients. Many orthodontists in recent years have stopped processing insurance claims since the cost of hiring additional administrative staff to comply with insurance company red tape outweighs the benefit they receive in return. Regrettably, this causes additional strain for the patient, who is then burdened with the task of completing complicated reimbursement forms and communicating with the insurance companies.

Three, administrative costs. Higher costs of insurance company compliance results in overall costs of patient care being increased. Many of the Nation's orthodontists who have longstanding practices report that insurance company benefits for orthodontic treatment have remained unchanged for over 20 years. This means even patients who are covered by insurance often bear the entire burden of increased health care costs.

Four, non-duplication of benefits. A related issue that affects orthodontists is what is termed non-duplication of benefits. This means that patients are covered by more than one insurance policy, yet the second policy will refuse to make any payment on behalf of the patient. It may be that both parents or a parent and a stepparent are employed and have paid the premiums for insurance that includes orthodontic coverage, yet will be unable to receive the benefit because of a non-duplication clause in the insurance policy. This means that the employee who happens to have insurance coverage through a spouse cannot access their benefits equally to an employee working for the same company who is not covered by the insurance plan even though both are paying the same premium. This situation is unfair to those who are paying for a benefit and not receiving it. This needs to be remedied. Therefore, the AAL believes that consumers who pay for insurance coverage should get the full extent of the coverage they are paying for instead of getting caught in a tangled maze of paperwork that ends with a denial of payment by the second insurer. Congress should require that where families have multiple dental benefit plans, each plan will pay a portion of the dental care claim according to their contracted scope of benefits, not to exceed 100 percent of the amount of the claim.

Five, coordination of benefits. The treatment fee is such that both plans will usually end up paying their maximum, but the secondary insurer will refuse payment until a primary estimate of benefits is received, causing additional payment delays and increased paperwork and expense for the office and insurance company alike. An effective repayment system that works best for my office from an insurance company are the ones that pay automatically once the initial billing is received. This cuts down on expense and increased work hours for both the orthodontic office and the insurance company. Manual monthly insurance billing is very time consuming and adds to the administrative expense for both the practice and the insurance company and this ultimately costs the patients more.

The AAL appreciates the opportunity to share the experiences and perspectives of our member orthodontists as the committee considers ways to alleviate the problems caused by late payments of benefits. I hope that the testimony I have offered has been valuable for that end, and I hope that if the AAL can be of further assistance to this committee, you will not hesitate to call upon us.

[The prepared statement of Dr. Merrill may be found in the Appendix on page 32.]

Chairman GONZÁLEZ. The next witness is from San Antonio, and he is Dr. David Henkes. I have known David—I know, Rick, you were saying you had known Dr. Merrill for a number of years. I hate to even tell you how long I have known David. He was starting his residency and I was already a seasoned 5-year lawyer, which is way, way back. And we share many things in common and that is a great passion for the University of Texas Longhorns.

Dr. Henkes hails from San Antonio. He is a board certified pathologist and the immediate past President of the Bexar County Medical Society in San Antonio. He currently sits on the Board of

Trustees for the San Antonio Medical Foundation and is on staff with Christus Santa Rosa Health Care, one of the top health care organizations in all of south Texas. Dr. Henkes is also a partner and practicing pathologist with Pathology Associates of San Antonio.

Dr. Henkes.

STATEMENT OF DR. DAVID HENKES, M.D., BOARD CERTIFIED PATHOLOGIST, PATHOLOGY ASSOCIATES OF SAN ANTONIO, PAST PRESIDENT, BEXAR COUNTY MEDICAL SOCIETY, SAN ANTONIO, TEXAS

Dr. HENKES. Congressman González and Ranking Member Westmoreland, and other members, I want to thank you very much. I would be nervous in giving this testimony except that I look at your friendly face.

Overall in Texas the prompt pay laws we have passed have been helpful, but they haven't really gone far enough. There are still some bad actors out there. In December of 1995, UnitedHealthcare was fined $4 million for violations. There is also the problem where the insurance companies tend to say they are ERISA and so therefore these are not regulated by States. Since most of their claims are ERISA, that has been an issue.

As you mentioned practicing in Christus Santa Rosa, it is a very—I am very honored and very happy to do that, but it is a very high Medicaid and Medicare and indigent population. So you can imagine how slow pay and no pay has a real impact on our practice, especially when we have specialized pediatric cardiac surgery, pediatric oncology, and we have to attract talent for their special pathology needs.

I want to tell you about an example in our practice that we had that extends beyond just the typical, you know, the slow pay for a claim submitted. In 2004, UnitedHealthcare had sent out a notice saying they would no longer pay for clinical pathology services. Clinical pathology services are services that pathologists provide to hospital laboratories for oversight and direction and usually comprise 25 to 35 percent of the time that a hospital pathologist spends doing those type of services. They said they were going to follow the Medicare model and to pay the hospital, which is indeed what Medicare does. But that is not the model of private insurance companies in Texas, and every other one pays us on a separate component basis. They said the services were covered and we should look to the hospital for that reimbursement. We did and the hospital said we are not being paid. They gave us signed statements of that and we asked them if they had any increase for the nonpayment to pay through to us and they said no. We went back to United and they said, oh, well, okay, we will change that, what we are going to do is—they changed their position and said we are going to go ahead and pay you a little bit more for your anatomic services to cover for these clinical services. Well, that brings in an ethical consideration because a number of patients who don't have clinical services—they don't—they have anatomic services and may not have clinical services. So they are paying for those other patients. And so we challenge that. And then finally, after having this within the Department of Insurance for Texas for almost 2 years,

we got a letter back from them just giving us a letter from United saying that they no longer recognize this service. And so we are not sure exactly what that means, whether it is covered or uncovered or what we need to do with that.

In essence, what I recommend is that this committee not only look at the existing rules and regulations from the States that are out there, but look at more detail at some of the other practices like what I have just mentioned and help us in terms of addressing those particular practices. I would suggest some of the following recommendations.

One, that insurance companies must state whether disputed services are covered or not covered, recognized or unrecognized. If a service is covered, it should be paid; there should be a payment for that service. Insurance companies should not be allowed to increase payment for one service to cover no payment or lesser payment for another unless it is specifically agreed to by both parties in a written contract. Payment to someone other than the provider or person who is authorized by that provider for reassignment should be prohibited.

The committee should consider a single set of rules on claims processing by all insurance companies as clinically based so there is transparency in the claims processing system. In cases of dispute requiring arbitration, the insurance company should pay the majority of the arbitration costs and contracts should not have provisions to deter class action arbitration or litigation. And just on that last particular item, we are currently in a class action arbitration and they are throwing up a number of hurdles about that basically so that it has made it very difficult but it will go forward and it should go forward.

I would be happy to answer any other questions. I appreciate your time and consideration.

[The prepared statement of Dr. Henkes may be found in the Appendix on page 36.]

Chairman GONZÁLEZ. Thank you very much, Doctor. At this time the Chair is going to recognize the ranking member, Congressman Westmoreland, for the introduction of the next two witnesses.

Mr. WESTMORELAND. Thank you, Mr. Chairman . I want to recognize Dr. Gordon Austin, a third generation dentist who graduated top of his class at the Medical College of Georgia. He completed his oral and maxillofacial surgery residency at the Naval Hospital in San Diego in 1993 and is board certified by the American Board of Oral and Maxillofacial Surgery and the National Dental Board, certified by anesthesiology.

Dr. Austin served for 11 years on active duty in the U.S. Navy and continues to serve in the reserves with 30 years of continuous service. Captain Austin was mobilized to the National Naval Medical Center in Bethesda, Maryland for Operation Desert Storm in 1991 and again in 2003 for Operation Iraqi Freedom.

Dr. Austin has been in private practice since 1987. He lives in Carrollton, Georgia, with his wife Meredith and daughter Courtney. And Lindsay lives up here in Washington, his other daughter. But Captain Austin served from 2002 until 2005 as the Reserve Officers Association National Dental Surgeon. He is cur-

rently the President of Northwest District of Georgia Dental Association. He is a friend of mine and a constituent. And welcome, Dr. Austin.

STATEMENT OF DR. GORDON T. AUSTIN, D.M.D., P.C., BOARD CERTIFIED ORAL AND MAXILLOFACIAL SURGEON, PRESIDENT, NORTHWEST DISTRICT OF THE GEORGIA DENTAL ASSOCIATION, CARROLLTON, GEORGIA

Dr. AUSTIN. Thank you, Chairman González. With the last name Austin, I certainly have a close kinship to the great State of Texas. Ranking Member Westmoreland, thank you for those comments, and members of the committee. I deeply appreciate this opportunity to testify before you on the issue of ensuring prompt payment for small health care providers. This is an issue of national interest and significant importance.

There are currently at least 48 different State prompt pay laws, with to my calculation only South Carolina and Idaho not having such laws. In the complex environment of health care, any opportunity to decrease this complexity should be acted upon.

Again, my name is Gordon Austin, DMD. I practice oral and maxillofacial surgery in rural Georgia. And as an oral and maxillofacial surgeon, I practice in both the hospital and the office setting. As a surgical specialty, oral surgery bridges the gap between medicine and dentistry. I file both medical and dental insurance claims. I am a Medicare provider and I am a Medicaid provider.

I have submitted written testimony and other information, so I will keep my remarks brief to allow as much time as possible for questions.

Although I am a proud member of the Georgia Dental Association, I come before you today not representing any organization but as a small businessman with a business issue. There are a couple of points I would like to emphasize.

As a congressional committee with expertise on small business, it is certainly no surprise to you that as a small business it is vital that I be paid promptly for my services.

Secondly, I believe action on this issue is a reasonable responsibility of the Federal Government because of the interstate commerce issues involved. Although I practice in Georgia, I file claims with insurance companies across the United States. A reasonable time frame for payment should be a consistent and national standard. ERISA plans are exempt from prompt payment laws, so Federal legislation would be necessary to fully establish the national standard.

Thirdly, will it work? Is it doable? Currently under Georgia Dental Medicaid with the ACS and Avesis insurance companies, I can examine a patient on Tuesday, do their surgery on Thursday, and have the money directly deposited in my account on Monday. If some of the Georgia Medicaid insurance companies can do this, any third party payor can if they are so motivated. Yet I have submitted to you documentation of a recent far too common case of services which I provided in March that still has not been paid in August, along with a lot of the phone calls and documentation provided to the company. This demonstrates the unreasonable time and unnecessary expense to my office spent resolving many claims.

Again, I thank you for this opportunity. I look forward to answering your questions.

[The prepared statement of Dr. Austin may be found in the Appendix on page 65.]

Mr. WESTMORELAND. Thank you, Dr. Austin. Now it is my pleasure to introduce Dr. Frank Kelly, who serves as Chair of the Communications Cabinet of the American Academy of Orthopedic Surgeons. Dr. Kelly also practices at the Forsyth Street Orthopedic Surgery and Rehabilitation Center in Macon, Georgia. A notable member of Georgia's medical community, Dr. Kelly has practiced in Macon for over 25 years. And he is a Phi Beta Kappa graduate of the University of North Carolina at Chapel Hill before completing his medical training at the Medical College of Georgia and his orthopedic residency at the University of Tennessee Campbell Clinic.

Dr. Kelly is the past President of the Georgia Orthopedic Society and is currently serving as a member of the Board of Directors of the American Academy of Orthopedic Surgeons, representing over 24,000 orthopedic specialists worldwide.

I want to thank Dr. Kelly for his willingness to come share his thoughts, and I look forward to hearing his testimony. Dr. Kelly, welcome.

STATEMENT OF DR. FRANK B. KELLY, M.D., BOARD CERTIFIED ORTHOPAEDIC SURGEON, CHAIR, COMMUNICATIONS CABINET, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, MACON, GEORGIA

Dr. KELLY. Thank you very much, Lynn. When I get back home, I don't know whether to tell my friends I went fifth or last. But perhaps fifth sounds better. Good morning once again, Chairman González. And good morning again, Ranking Member Westmoreland. And good morning to other distinguished members of this subcommittee.

As Lynn mentioned, my name is Frank Kelly. I am a practicing orthopedic surgeon in my hometown of Macon, Georgia. I also have the pleasure of serving as a member of the Board of Directors of the American Association of Orthopedic Surgeons. And I served as a Chair of our organization's Communications Cabinet.

On behalf of my organization and behalf of my colleagues across the country, I sincerely thank you for asking me to testify this morning on this very significant issue of prompt payment for health care services.

As a practicing physician and as administrator of a seven-person practice, I am deeply concerned that the Federal Government has simply not done enough to ensure that physicians in practices like mine are paid promptly by insurers. Having now been in practice for almost 30 years, I have witnessed firsthand how this delay in reimbursement has not only made it more difficult for us to run our practices, but it has already had the very real potential of adversely affecting the quality of care we deliver to our patients.

Though we have tried to cooperate with insurance companies, unfortunately the vast majority of so-called clean claims, those claims submitted in accordance with the insurer's own guidelines, are not reimbursed in a timely manner. In fact, as has been mentioned several times this morning, these claims can average 3 to 6

months before payment and they can constitute a very major burden for those of us who depend upon this income for the day-to-day operation of our practices.

In response to concerns from physicians nationwide in an attempt also to address this significant problem, as has been mentioned already, almost all States have enacted prompt payment laws mandating that third-party payors reimburse claims in a reasonable time period. My home State of Georgia, as has been mentioned this morning, is fortunate to have one of the most comprehensive and effective laws governing prompt payment for medical services. Under our State law, insurers must process payment within 15 working days after receiving these clean claims, otherwise pay a penalty of up to 18 percent of the benefit due.

Our insurance commissioner, John Oxendine, has been unyielding in his enforcement of this law and in his commitment to our State's physicians, ensuring that big insurance companies don't take advantage of our small medical practices. Unfortunately, Commissioner Oxendine's reach extends only so far under the current Federal law. Approximately half of my patients and over 100 million patients across our country are covered by self-funded insurance plans which fall under ERISA, the Federal Employee Retirement Income Security Act. And according to the Supreme Court's decision in a 2004 case, these ERISA plans are exempt from State prompt payment regulations. As a result, thousands upon thousands of claims are slipping through the cracks in this system.

While insurance companies may argue that the administrative burden of processing claims prohibits timely payment, I find this to be a hollow and very ineffective argument. Even Medicare, the Nation's largest health plan, adheres to a higher standard than do these ERISA plans. In fact, the Social Security Act requires that accurate Medicare claims be processed in 30 days or be subject to a significant interest penalty. Prior to the enactment of our State's prompt pay law, practices like mine relied heavily on Medicare for our monthly cash flow to meet the expenses of running our practices. Many of my colleagues and States with less aggressive prompt pay statutes still struggle with late payments from private insurance companies. They still depend upon Medicare reimbursements to cover their expenses.

Though much work still needs to be done, I have seen the very positive impact of Georgia's prompt payment regulations on our State's health care system and on the many hard working physicians and small businesses within it. I am confident this problem of delayed reimbursements can be overcome throughout our country. This will require accommodation of at least three things.

Number one, effective, extensive prompt payment legislation.

Secondly, the accurate determination of what really constitutes a clean claim.

And thirdly, and perhaps most importantly, appropriate enforcement mechanisms to ensure that insurance companies are adhering to these regulations.

Our association supports prompt payment within a 30-day timeframe. Such timely reimbursement will allow us to spend more

time doing what we were trained to do, and that is taking care of our patients.

On behalf of my orthopedic colleagues, on behalf our association, I thank you very much for your time and for your interest and for the opportunity to express to you my concerns about this most important matter. Thank you very much.

[The prepared statement of Dr. Kelly may be found in the Appendix on page 67.]

Chairman GONZÁLEZ. Thank you, Dr. Kelly. We have been advised we have got two procedural votes and I think we have the 10-minute bell. Around the 5-minute bell we will head out back to the floor, vote. Two procedural votes, that could mean anything. Congressman Westmoreland could probably give me some insight as to what the Republicans have in store for us. I don't think he will. As soon as we are through, we will come back. I will ask one question and get it started. Then we will probably have to excuse ourselves. Please stick around. Staff will tell you more or less the time frame once we get down there and start voting. But there are two votes and conceivably that could be 20 minutes or 30 minutes.

But Dr. Wilson, there are certain things that kind of resonate. First of all, it appears everybody is in agreement that there is a role for the Federal Government and yet still leave room for State mechanisms to take effect, which I think is always the best thing we can do. But one thing that struck me in reading the testimony from all of you, but especially Dr. Wilson and I believe Dr. Kelly and some others, this thing about uniformity. It is surprising to me that at this point in time that there isn't some sort of uniformity on what a clean claim looks like, the minimum amount of information that has to be reflected on there that would be sufficient, though, for the insurer to go ahead and act on it, because it appears that there is a game that goes on obviously. And I think I will get to Dr. Henkes and he can explain what happened in his particular episode in San Antonio.

But have there—obviously there have been efforts to try to come together on what some sort of uniform information would be required?

Dr. WILSON. Yes. Thank you, Mr. Chair. And certainly there have been and certainly the AMA has been involved in a lot of those efforts, in getting uniformity in terms of the claim form as well as the requirements for a clean claim. The challenge, of course, is that each of the insurance companies is an independent business. They sometimes would claim that there is some antitrust provisions that would prevent them from cooperating in some ways. I don't think we buy that argument. But the reality is they have not been able to come up with something they all agree with that would mean a clean claim.

The other thing that physicians face is what is called black box edits, and that is for any one insurance company they won't tell the physician what their requirements are. So you might have 10 companies you deal with and at a minimum if they would just let you know, what are the 10 things that ought to go into a clean claim, that would help the physician. Frequently those are considered proprietary and not available and not provided. So the physician finds

out what is missing from a claim when he gets the claim back and says, well, you missed this. And unfortunately, sometimes you will correct that and then you get the claim back again and say by the way, here is something else we want you to correct as well. And each of those, of course, retolls the hours in terms of prompt pay which make that a challenge.

The point is well made. We need some uniformity there. And there are times when the Federal Government can provide that uniformity and this is one of those.

Chairman GONZÁLEZ. Sir, we always hear here in Congress that many times whatever Medicare—what the United States Government through Medicare establishes, what would be a reimbursement rate for any procedure, a protocol and so on that generally insurers will then adopt that particular baseline reimbursement rate. Is that accurate?

Dr. WILSON. The reality is more and more of the insurance companies are pegging their rates. They won't necessarily make that the same rate. But if as is anticipated—and we would hope Congress is going to block that. If we come January 1 and are faced with a 10 percent cut in Medicare payments, you can be sure that insurance companies will look at that and adjust their rates. Now, they won't all come down to Medicare levels, but they will use that as a model which then will obviously impact everyone adversely.

Chairman GONZÁLEZ. The reason I ask that, it seems that they are pretty willing to go ahead and adopt that which the Federal Government may establish if it works to their advantage but not necessarily other practices by the Federal Government when it comes to, say, Medicare. So I think we can maybe give them a little bit of guidance.

At this time, the committee will stand in recess and we will reconvene as soon as that second vote or the last vote. Thank you for your patience and see you in a few minutes.

[Recess.]

Chairman GONZÁLEZ. The subcommittee will reconvene at this time. I will yield to the ranking member for any questions he might have since I had the privilege of getting a few minutes in earlier.

Mr. WESTMORELAND. Thank you, Mr. Chairman . And I want to thank all of you for coming. And I know a lot of people don't look at it as being—in the medical profession as being a small businessman. But coming from a small business background and knowing some of you personally, I know that it is a small business and that cash flow is critically important. And I am going to ask Dr. Austin this. Does a delay in provider reimbursement threaten to Dr. ve some of the small providers out of business? And if that happened because of this pay issue, what would the effect be on both the provider and the patients?

Dr. AUSTIN. Thanks for the question. I just wanted to say to the Chairman I really appreciated his comment about the Medicare rules. I believe you get it, that the insurance companies use what is to their advantage and this card was not to their advantage.

It is really pretty simple in terms of running a business. The more hassles you have in a business, the more difficult it is to make a profit, the lower incentive there is to go into the business. So if the bottom-line continues to deteriorate, it is harder and hard-

er to attract the best and the brightest to the professions. It is particularly problematic for small specialties like my own.

The orthodontist as previously—the issue of being an orthodontist. When I was on the Medicare Carrier Advisory Committee, I was talking to the medical director about some issues that we had. And he said, you know, Gordon, we get 6,000 complaints from the cardiologists and we get six complaints from the oral surgeons and we just don't have time to get to your issues. And so that is really what happens to the small practitioners, is that we get pushed to the back of the line. And because we are small, it affects us more. If I do four surgeries in a day and one of those claims doesn't get paid, that is 25 percent of my income that doesn't happen. If you were in a large group, that is a smaller percentage and more easily absorbed. So it affects the smallest businesses, the smallest practitioners the most.

Mr. WESTMORELAND. Just one follow-up if I could. And this would be to anybody because you may all have different circumstances. But what are some of the excuses or practices or dilatory things that these insurance companies do to prevent you from being paid promptly.

Dr. AUSTIN. It is pretty easy in my case. I do the same type of procedures over and over and over again and we face the same issues. A large part of my practice would be taking out wisdom teeth on a young person. We know that they are going to ask for an X-ray. We know that if we take out a little cyst, they will ask for a path report. And we know if they are a student, they will ask for proof of student status. We routinely send these in with the claim and yet we routinely get the claim back saying send us an X-ray. We call them and say you have the X-ray. They say, oh, yes, we do have the X-ray. They say send us the student status. We sent you a student status. Oh, well, maybe we didn't get it. So they know what stops the clock, and that is really what the issue is. The States have put a clock on them to pay the claim and they know if they can say it is not a clean claim, they are missing something, it stops the clock. So even when we send it, stamp on the claim that we sent it, they still when we call them or get the letter back, they ask for something we have already sent them.

Dr. KELLY. If I might, I would like to echo Gordon's comments because I found the same situation in my orthopedic practice. One of the things I do, as you might imagine very commonly, is a knee injection. It is a very simple technique. It takes just a few moments. The same situation. We will submit the claim, they will send a letter back that always says—they send it back and they say we notified your patient 17 days ago. They always say 17 days ago that we received this bill and we need to have from you the patient's history and physical, any pertinent lab tests, pertinent X-rays, progress notes, anything to game the system.

I think the Chair had it right earlier. I think it is almost like a game they are playing just to delay payment. So we have the same situation with knee injections in our procedures that Gordon does in his practice and it has just escalated.

Dr. MERRILL. Probably the most common thing with braces is when there is two insurance policies that cover—the average fee for braces is well in excess of what the lifetime maximum is. And sec-

ondary insurers will delay payment by saying, well, we are not going to issue our estimate of what we are going to pay until after the payment is received from the first insurer so we know what they'll pay and then we'll tell you what we are going to pay, even though both are going to pay that full amount. It is just a matter of being able to delay it an additional 3 to 4 months, which provides uncertainty to the patient. The patient is, like, do I have this or do I not, am I going to have to find another $1,000 or $1,500 to pay towards this or will my insurance pay for it? And my office staff have to explain that to the patients and they don't understand how the insurance companies work. And so it is very disconcerting to the patients when that happens, as well as being a problem for cash flow as you have alluded to.

Dr. WILSON. One of the things that has happened along with the prompt pay laws in States is insurance companies now have a new category, which is called pending review. And so you get the report back—and I mentioned this in my written testimony—that pending review doesn't tell you what it is they are looking at. It is like a concurrent audit and then that postpones the prompt payment and then ultimately they will say what it is that they want.

Mr. WESTMORELAND. And just a little follow-up to that. Like Dr. Gordon and Dr. Austin and I am sure Dr. Merrill, you do the same thing over and over. So you know what they are going to ask for. Is there any type of checklist or something that you send in with a claim or is there requirements that they have given you that you routinely know? I mean, I understand how they are doing it, but I mean, it is really inexcusable if you do these things over and over and over and know what they are going to ask. Would one patient be different from another?

Dr. KELLY. I will start that, Lynn. I think the incredible thing about this is we use the insurer's own guidelines. They ask us what to submit. We use their own guidelines for our claims. And even though we have followed their guidelines to the letter, they still come back requesting other information.

I would request that sometime when you are in the Macon area, please stop by my office for 30 or 45 minutes. You will be just absolutely amazed at the type of requests that we get from the insurance companies.

So they have guidelines, we go by them. It doesn't seem to matter.

Dr. AUSTIN. The claim itself—we have codes and the codes very clearly define as to what the procedure is that we are doing. So in theory, when we have submitted that claim with the code, we have told them exactly what we are doing, how we are doing it. And as I said, with Medicaid I can send it in on Thursday and have the money in the bank on Monday. It is not a matter that they can't do it. It is purely a matter of in their minds it is a business advantage to not pay in a timely manner. And they are much better at it than I am.

And that is kind of where the issue comes in. The best people that are gaming the system are the insurance companies. The next people are the people that do regulations, Medicare, that set guidelines. But the person that is least able to really keep up with the changes is the small practitioner. So we are always a little behind

the curve. The insurance company is always a little bit ahead of the curve and the regulations are somewhere in the middle.

Dr. HENKES. Congressmen, as well, you have to realize too if you have four or five major players in one area, you are also playing with four or five different sets of rules. And that is why I believe that the more uniformity in the sets of rules would be better. Each one may have their own sets of rules, as Dr. Wilson had mentioned. Some of these are black box edits. They won't even tell you what the rules are.

Dr. WILSON. I guess the other observation about, well, can they do it if they want to—well, someone said how does it happen with Medicare. And clearly there are rules for Medicare. And while if you look at prompt payment for Medicare across the board, it is about somewhere in the middle. However, for example, in my own personal example, which is solo medicine—and I file electronically and I can tell you that the Medicare carrier meets the requirements, the 14-day requirement for a turnaround on electronic billing. And it seems to me that—and obviously those are the major health insurers who are contracted with Medicare. And that to me speaks to the issue that if the incentives are appropriate, if the cloud is there, in this case the Federal Government, then they will be able to meet some standards that are put in place.

Chairman GONZÁLEZ. The Chair is going to go and recognize Jason Altmire. And again, Congressman Altmire, thank you for joining us.

Mr. ALTMIRE. Thank you, Mr. Chairman and Mr. Ranking Member. I would just say very briefly it looks like we will have some disruption here to this hearing but that should not indicate that this committee doesn't understand the significance of health care as an issue to small businesses. And I just wanted to thank each and every one of you while we had you here together for your appearance here today and let you know we want to continue working with you as we move forward on this issue. There is no issue like this across the business world where small businesses are affected by health care every single day, every business in the country. And I really appreciate the fact, we appreciate the fact that you took the time out of your day to come help us with this hearing and walk us through your issues. And we look forward to continuing that discussion and just to apologize again for the disruptions that apparently we are going to be facing throughout the hearing. Thanks.

Chairman GONZÁLEZ. Thank you very much. Let me direct a question to Dr. Henkes. You pointed out an interesting case that you had with UnitedHealth and it is not for us to paint with a real broad brush. But nevertheless, the concern that we have, Republicans, Democrats, it doesn't matter, is that we have a business model that has been institutionalized by the insurance industry. The insurance industry is a very essential component to the way we do business in this country and we need a healthy insurance industry. But nevertheless, our fear now is that they have basically built into their business model a manner in which to delay payment for what very well could be obviously the business considerations of holding on to that money, the investments and so on that

it brings. So, Dr. Henkes, you have pointed out the experience with UnitedHealth and how you had to go and address that obviously.

The other thing that you pointed out in your written testimony was the concern—and some of the other witnesses also pointed out and I wanted to touch on this quickly—and that is some Federal clarification legislatively on the application of ERISA and how that plays a part in maybe complicating what can be done with insurers and the question of prompt payment. What is the position on ERISA and how do you see it?

Dr. HENKES. Well, I don't think that the picture is entirely clear. From my understanding on this, there has been some discussions with the Department of Trade and that they have seen some ambiguity into whether this really has any kind of—they have jurisdiction over the prompt pay on this. We know at the Texas Department of Insurance there has been ambiguity by the researchers there as to whether the current laws apply, being State laws on to—for ERISA plans. I actually am on an advisory committee for an insurance company in Texas and they have taken the position that they do not. Of course I don't think this one has been actually totally played out. I think there may have been one court case in another State that may have given some credibility that maybe payment issues are not necessarily preempted by ERISA. But there still is a lot of ambiguity.

So I guess at this point, I think the State agencies, as well as the Federal, are in ambiguity in how this affects on the ERISA plans. And I think that is why it is so critical to have you and this committee look at that to give that clarity and give that clarity that if it requires passing another law or if the compliance—that this is a part of State law.

Chairman GONZÁLEZ. I will advise you all—and I would need to do more research on this. I didn't have time to do it and check the status. H.R. 979 is the Bipartisan Consensus Managed Care Improvement Act of 2007, and it would amend ERISA. Among some of the provisions would be to impose prompt payment requirements on all employer-sponsored health plans. The act requires such plans to pay all clean claims consistent with existing requirements under the Medicare program.

So obviously there are other committees that share jurisdiction. Much to our credit, the chairwoman of this committee, Chairwoman Velázquez, was able to expand the jurisdiction of this committee to share some of the jurisdiction with other committees. So we still have to work in unison. So it is obviously being addressed. We just need to see where we can try to coordinate this.

Dr. Kelly, I think you were pointing out again, if we can come up with the proper role for the Federal Government and, of course, Dr. Wilson was also very specific as to what extent we could do that. Dr. Austin also touched on that and I think that is going to be our focus. What can we do to come in with a Federal standard? Again, that is establishing basically the floor, working with the States, which would be really more of the enforcement mechanism, and of course if they have higher standards, not to interfere and meddle with that. At least that is my perspective, and I think Congressman Westmoreland may have a different take on it.

Also, I think we need to start looking at uniformity out there so that we don't have companies that basically say we don't have the information, you add on to it. If they choose to do that, there should be an additional burden placed on them with some consequences. And that is the only way you ever get accountability, is where there is consequences, which I don't think we have that at the present time.

So there is much to be worked on. By the same token, I also wish to address many of the other items that you may have brought up in your written testimony addressing other trouble spots, not just the prompt payment. But I think that right now for the purpose of this hearing—and we will share the other recommendations and observations you made as to other, what I would say, difficult areas in practicing medicine.

I also want to make another observation, and that is simply that this is the Small Business Committee. Most physician practices are small businesses, as has been pointed out. We recognize that you all are in a very unique position as physicians. You have to conduct yourselves as a business so you can open your doors in the morning and make sure that they are open every day. And that is a business. Nevertheless, I still consider you the last standing profession in the United States of America, and somehow you have to maintain that even in a business environment, and we are here to help you do that.

We have another vote. We are going to be leaving in a few minutes, and I don't know how long it is going to take. So what we are going to be doing is basically adjourning and letting you all catch your flights and such. And I know some of you said you wanted to take some pictures. So I want to give them that opportunity.

So at this time, I would yield to the ranking member for any comments he may have or any follow-up questions.

Mr. WESTMORELAND. Thank you, Mr. Chairman .

Mr. WESTMORELAND. Let me just thank you for having this hearing because I think this is a very important issue. I do agree the Federal Government does need to have a part in it.

One quick question. How many private insurers handle Medicare in your States, do you know a number?

Dr. WILSON. For Florida, it is just one.

Mr. WESTMORELAND. For Florida it is only 1.

Mr. WILSON. It is Blue Cross/Blue Shield.

Dr. HENKES. In Texas we have the standard program, a Medicare program, but there are some replacement programs, HMO replacement programs.

Mr. WESTMORELAND. Medicare Advantage type thing?

Dr. HENKES. There are probably 5 or 6 of those, maybe 6 or 7.

Mr. WESTMORELAND. In Florida it says there are 289 different plans for the Medicare Advantage; is that true?

Dr. WILSON. The answer is I do not know that, and I responded to the wrong question. When you said Medicare, I tend to think of the Medicare carrier and not the Medicare Advantage plans, but there are a lot of them.

Mr. WESTMORELAND. Okay.

Dr. HENKES. We can get that information for Texas.

Mr. WESTMORELAND. I was wondering, I know the Medicare Advantage is a little bit different program than Medicare itself, with a little different payment. I was noticing we happened to be talking about the Medicare Advantage program and I was just looking at the different providers, 289 of them in Florida. Do they all have to agree to the prompt pay or to the payment that Medicare prescribed to be able to offer that?

Dr. WILSON. One would assume.

Mr. WESTMORELAND. I would assume that, too.

Thank you, Mr. Chairman , for having this, and again we are going through some procedural stuff right now, a little disagreement, but I thank all of you for coming.

Chairman GONZÁLEZ. I will tell you this right now; that we are conducting ourselves like insurers on prompt payment.

Well, I think we're still going to make this vote, but I would like the opportunity to go out there and thank you personally. And Lynn, if you have a chance to also join me.

I will do something a little different and instruct staff to get together. I want them to summarize some of the testimony regarding identifying everything that everyone agreed on, and what would be the remedy in order for us to share that with other members of this subcommittee as well as the full committee.

And I ask unanimous consent at this time, the members have 5 days to enter statements into the record. And this hearing is now adjourned.

[Whereupon, at 12:00 p.m. The subcommittee was adjourned.]

STATEMENT
of the
Honorable Charles Gonzalez, Chair
Subcommittee on Regulations, Health Care and Trade of the
House Committee on Small Business
Hearing on
"Ensuring Prompt Payment for Small Health Care Providers"
Wednesday, August 1, 2007

This hearing on ensuring prompt payment for small health care providers is now called to order.

Small physician groups face many challenges today. Unfortunately, many of these have nothing to do with practicing medicine. Whether it be the increasing bureaucracy of managed care or the prospect of reduced Medicare reimbursements, it can be extremely difficult to make these businesses profitable. Today's hearing will look at one of the biggest financial challenges facing the industry.

Payments from insurance companies to health care providers have long been a concern of health care providers and their member organizations. Providers have shown that insurers delay payments for a significant portion of insurance claims. This often leads to cash flow problems and increases the cost of care for the patients they serve. Such conditions are particularly problematic for small health care providers.

As small businesses, they just cannot afford to be exposed to the sort of instability that an unpredictable revenue stream creates. Payment delays are nothing more than unfair business practices that let insurance companies earn interest on money owed. Cash flow is an important issue for the small practice and late payments hinder their ability to run and expand their business.

The insurance community would like us to believe that the prompt payment of claims is not a problem; that the market in concert with state laws will address any lingering problems. An honest appraisal of the health care arena tells us that insurance companies, the goliaths of the industry, are driving the market and deciding who will be the winners and losers.

Small providers lack the financial resources to hold insurance companies accountable for their failure to make timely claims payments. If an insurer is unwilling to make a payment or wants to delay payment, what remedy do small practices have at hand to compel payment unless we provide them with one. Only prompt payment laws that are enforced make it possible for small providers to be paid in timely and fair manner.

Efforts to enact prompt state payment laws have been successful. To date, all 50 states and the District of Columbia have prompt payment rules that apply to insurers. These laws were designed to help to small providers who lack the ability to negotiate payment schedules with insurers or compel payment. As such, small business health care providers can rely on state efforts, as opposed to hiring their own attorneys, to enforce these requirements.

But there is a problem. States do not seem to be effectively cracking down on insurers who are not complying with state prompt pay laws. In part, the focus of today's hearing is to understand why prompt pay laws fail to be as successful as providers once hoped.

Ultimately, health care providers need prompt payment laws that are meaningful in practice, not just on paper. I believe this means promoting stricter enforcement of existing laws, strengthening prompt payment requirements, and holding more health plans accountable.

Though prompt payment laws can be found through out the country, providers seem to uniformly agree that they are far from effective. This is a significant source of frustration for state insurance commissioners who have directed considerable resources toward enforcing compliance and providers who challenged by the problem daily. Without a solution, small practices will continue to struggle.

I would like to thank each of our witnesses for taking time out of their schedules to discuss this important issue.

Opening Statement of
Ranking Member Lynn A. Westmoreland
Committee on Small Business
Subcommittee on Regulation, Healthcare, and Trade

"Ensuring Prompt Payment for Small Health Care Providers"

Wednesday, August 1, 2007

Thank you, Mr. Chairman, for holding this hearing today. I would also like to thank all of the witnesses for their participation. I am sure that today's testimony will prove to be very helpful.

Payment for service is the core of our economic system. No industry would survive if those who bought a product only paid a fraction of what it cost. But that is exactly what is happening to physicians in our health care industry, and not only are physicians often being paid less than what their services cost, they are also being paid well after the bill comes due.

The ironically named "prompt payment" issue is one that is affecting physicians and patients all over the country. Surveys have shown that it is at the forefront of physicians' concerns. I don't know about any of you, but when I visit my doctor I want his full attention to be on what he is doing, and not wondering if he will get paid for his work.

Almost every state has enacted some form of prompt payment law in an effort to address this very real issue. Unfortunately, these laws usually have very little enforcement and therefore allow the problem to persist.

I am proud that my home state of Georgia has one of the most comprehensive laws governing payment for medical services. Our law requires that insurers pay clean claims within 15 working days of receipt. While this law has helped, it has by no means eliminated insurance companies' desire to withhold payment.

This Congress faces a great challenge as it tries to lower the overall cost of health care, while also providing access to those who need it. I hope that we can all agree that shortchanging our physicians is counterintuitive to having an effective health care system. I know that today's hearing will be helpful in addressing this challenge.

I welcome this distinguished panel, and thank you all for your willingness to testify.

Statement

of the

American Medical Association

to the

Subcommittee on Regulations, Health Care and Trade
Committee on Small Business
United States House of Representatives

RE: Ensuring Prompt Payment for Small Health Care Providers

Presented by Cecil B. Wilson, MD, AMA
Immediate Past Chair

August 1, 2007

Division of Legislative Counsel
202 789-7426

Statement

of the

American Medical Association

to the

Subcommittee on Regulations, Health Care and Trade
Committee on Small Business
U.S. House of Representatives

Presented by: Dr. Cecil B. Wilson, MD, AMA Immediate Past Chair

August 1, 2007

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding the issue of prompt payment by health insurers and the impact of payment delays on the operation of small health care practices. We commend Subcommittee Chairman Gonzalez, Ranking Member Westmoreland, and Members of the Subcommittee on Regulations, Health Care and Trade of the Small Business Committee for your leadership in recognizing the need to examine health plan conduct that threatens the ability of physicians to maintain their practices and provide the best possible care to their patients.

The focus of today's hearing is of great importance to the medical community given that 50 percent of physician practices have less than five physicians, and yet account for 80 percent of outpatient visits. The relatively small size of so many physician practices is in pronounced contrast to the size and leverage of health insurance companies. A select number of health insurers have garnered substantial market share. In the majority of Metropolitan Statistical Areas, a single health insurer dominates the market. For example, in 299 of the 313 markets that the AMA surveyed, one insurer accounts for at least 30 percent of the combined health maintenance organization (HMO)/preferred provider organization (PPO) market. At the same time that insurers are gaining more market control, physicians' relative leverage to negotiate reasonable contract terms has decreased. As such the ability of physicians to address unfair payment practices continues to diminish precipitously with the increasing consolidation of health insurers. As explained below, the viability of small physician practices, patient choice, and quality of care are imperiled.

Physicians are increasingly assuming additional costs to handle burdensome administrative measures to pursue payment from insurers. In fact, a growing number of physician practices, large and small, have been forced to hire office staff dedicated solely to collecting delayed payments from insurers. The foregoing is exacerbated by a number of industry practices including the emergence of "rental" networks that result in delayed and decreased physician payments. Small physician practices are particularly hard hit by

the drain on revenues. Some physicians have had to eliminate certain services and clinical staff as well as forgo equipment upgrades and the adoption of health information technology, in order to hire additional administrative staff to collect claims from insurers. Fundamental fairness coupled with the financial demands faced by small physician practices warrant timely payment.

The growing disparity in bargaining power between small physician practices and health insurers not only results in unfavorable contract terms for physicians, but has contributed to an environment where insurers are able to strategically side step statutory and regulatory safeguards with minimal risk of repercussions. It has been well documented by state regulators and in multi-district litigation that health insurer payment tactics have systematically run afoul of existing laws. This, unfortunately, only tells part of the story. Penalties and fines have not deterred insurers since such costs are less than the revenue stream generated by delayed or inaccurate payments. Furthermore, as the consolidation of insurers has accelerated and their market control has grown, regulatory oversight has not kept pace. Many health insurer tactics to delay or decrease payments remain under the radar or beyond the reach of regulators because of statutory shortcomings. The detrimental financial consequences are borne by physicians and ultimately patients.

Prompt Payment of Claims

State prompt payment laws and regulations protect patients and physicians from the unfair business practice of delaying payment for the provision of medical care. Failure to comply with these laws can have significant and in some cases financially debilitating effects on small physician practices and limit patient access. Yet often, patients and physicians have little, if any, recourse to challenge health plan actions.

Late payment of claims by health insurers (including insurers, HMOs, PPOs, third-party administrators, and other entities administering health plans) is a common problem for many physicians in a wide range of practice settings. In some communities, it has become so chronic and widespread that it has created serious financial hardships for physicians whose practices rely heavily on delinquent carriers. It also creates an onerous administrative burden on physicians and their staff who must spend hours on the phone with health insurers pursuing payment of unpaid claims. These same hours too often turn into days and months—a welcome timeline for some health plans, as a share of health plan revenues come from the interest accrued on the monies owed to physicians. Physicians who have provided services, on the other hand, and have abided by the terms of their contracts, cared for their patients, and submitted proof of claims for reimbursement, often remain unpaid and not even notified that there are problems with the submitted claims.

Delayed or denied claims typically require that physicians expend significant resources to handle burdensome administrative processes associated with securing payment. Even if a claim includes all the appropriate information (a "clean" claim), a physician is often still forced to continually track and pursue payment on these unpaid claims. Delayed payment for the provision of medical care is tantamount to small physician practices

extending interest free loans to large insurance companies. It gives the health plan the benefit of holding the payment and earning interest on it, while the physician, who has already provided the service, is deprived of payment. It is unfair for health plans to reap the profits from interest on premium dollars when they have outstanding bills to pay.

Health insurers are able to prolong delays by alleging that additional information is needed to process a claim. If a plan denies a claim based on a need for more information, the provider must comply by supplying the missing data. This is fair, as some providers do not fill out claims properly. Some plans, however, fail to list all of the additional required information when a claim is initially denied, instead notifying the physician in a piecemeal fashion—identifying one missing item on the first denial, and then when they receive the initial missing information, sending notice that still more information is missing. In some cases, every time a plan sends a physician notice that a claim is not complete, the number of days the plan has to pay a claim re-tolls.

In addition to the negative impact on physician practices, delayed payment adversely affects patients and access to care. When physicians cannot secure payment from health insurers, they are often forced to bill patients directly for services. This causes significant confusion and aggravation for patients, who assume that their claims are being paid in a timely manner by their health plans. It also forces them to pay out-of-pocket for covered medical expenses and then pursue payment from their health insurers at a later time. In addition, if certain physicians continually lose money due to consistently late payment from particular health plans, they may be left with no choice but to terminate contracts with those particular insurers—resulting in patients losing access to their chosen physicians and hospitals. This disrupts the continuity of patient care and interferes with established relationships between patients and physicians.

Health Insurer Practices

Prompt payment is just the tip of the iceberg when it comes to problematic payment practices. While timeliness of payment continues to be an important issue for physicians—including those in smaller practices—there are a host of other strategies utilized by insurers that prevent physicians from receiving fair and reasonable payment. For example, many health insurer contracts make material terms, including payment, wholly illusory. They often refer to a "fee schedule" that can be revised unilaterally by the health insurer. In fact, many contracts allow the health insurer to change unilaterally *any* term of the contract. Given the dominance of a select number of insurers in a large number of markets, the imbalance in negotiating power effectively makes the insurer contract terms a "take it or leave it" proposition for physicians.

Furthermore, these contracts frequently contain such unreasonable provisions as "most favored payer" clauses and "all products" clauses. "Most favored payer" clauses require physicians to bill the health insurer with greatest market share and control at a level equal to the lowest amount the physician charges any other health insurer in the market. This permits the dominant health insurer to secure the lowest input costs in the market, while creating yet another barrier to entry by competitors. Similarly, "all products clauses"

require physicians to participate in all products/plans offered by a health insurer as a condition of participation in any one product/plan. This often includes the health insurer reserving the right to introduce new products/plans and automatically requiring the physician's participation in the new plan/product. Given the rapid development of new products and plans, the inability of physicians to select which products and plans they want to participate in makes it difficult for physicians to manage their practices effectively.

Health insurers have also devised methods of denying and reducing payment by refusing to honor valid assignments of benefits executed by a patient who receives care from a non-contracted physician. This means that health insurers, rather than pay the non-contracted physician directly, pay the patient for the services provided. Small physician practices must allocate additional staff time to then seek the payment from patients. This further delays payment and, in some cases, effectively forecloses payment where a patient uses the funds for other purposes and has limited assets.

Similarly, many health insurers engage in the practice of "repricing" of physician claims. This process entails the health insurers adjusting a physician's billed charge for services to an allowed amount based on a fee agreement between the parties. Insurers then adjust this amount further based on claims processing rules that are not standard across the industry and not necessarily based on the medical payment policies of the plan.

Compounding the above concerns, physicians face additional payment processing challenges that further depress physician payments. A major concern has been the expansion of "rental networks." These networks are unregulated and allow insurers to employ a complex set of relationships to obtain the deepest physician discounted rate that may be unrelated to any rate that the physician has agreed to in a contract with the insurer. Navigating and untangling this web requires physician staff to perform costly, time-consuming audits to identify which entity applied the discount and which contractual agreement contained the applied discounted payment rate. Only then can a practice determine and appeal any inappropriate discounts that may have been applied to a claim. The result of discounting practices by insurers has decreased payments and increased claim payment reviews and audits. In a small practice this translates into scarce resources allocated to administrative functions instead of patient services and delivery. All of these industry practices threaten the viability of small physician practices.

Federal efforts to remedy physician payment barriers should not be limited to prompt payment, but should also address insurer claims processing abuses. Beyond the AMA's recommendations concerning prompt payment, we urge Congress to expand funding to ensure enforcement of existing federal standards set forth in the electronic transactions and code sets requirements found in the Administrative Simplification portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Current Environment

Currently, 49 states and the District of Columbia have either passed legislation or promulgated regulations tied to the prompt payment of claims. Despite the increased protections these prompt payment laws provide, physicians still experience problems with receiving payments from health plans in a timely manner. Based upon studies initiated by the AMA and state medical associations, most health insurers have decreased their delays in payment to physicians over the course of the last six years in states where there have been prompt payment laws and sufficient oversight and enforcement.

While some progress has been made, health plans continue to utilize loopholes in state prompt payment laws, allowing them to delay, deny, or only partially pay claims. The top reason identified for delays in payment has been claims "pending review." Such a strategy allows health insurers to delay claims, sometimes indefinitely, without any indication as to what or why the claim has been "pended" or what specific review is being initiated. Health insurers have also employed retrospective audits—paying claims in a timely fashion in order to comply with state law, and then decreasing payments at a later date.

To date, more than $76 million, including fines, interest, restitution, and statutory penalty fees, has been levied against third-party payers for untimely payments to physicians and other health care providers. In early 2000, almost two dozen state and county medical societies and a number of physicians who were no longer willing to tolerate the unfair business practices of some of the nation's largest for-profit health plans filed lawsuits in a number of states and in federal court. The lawsuits were filed against Aetna, Inc., CIGNA Corporation, Health Net, Inc., Coventry Health Care, Inc., Prudential Insurance Company of America, United Health Group, WellPoint, Inc. (Anthem, Inc.), and Humana Inc. The individual lawsuits were consolidated as part of a multidistrict litigation (MDL) before U.S. District Judge Federico Moreno in Miami, Florida, on October 23, 2000.

The lawsuit alleged that these health plans employed improper and illegal reimbursement practices used by the managed care industry to delay or deny payment by breaching prompt pay laws among other unfair reimbursement business practices. To date, Aetna, Inc., CIGNA Corporation, Health Net, Inc., Prudential Insurance Company of America, WellPoint, Inc. (Anthem, Inc.), and Humana, Inc., have settled their respective lawsuits. These settlement agreements provide for greater transparency in each settling payer's claims processing and payment practices. In addition, each settlement requires that where state law offers more protection than the settlement terms, the state law would apply. These settlements, however, will begin to sunset this year. The CIGNA Corporation settlement is the first to end on September 4, 2007.

Proposals

To address widespread, systematic insurer payment delay tactics, the AMA recommends a number of legislative changes that will ensure small physician practices have the necessary tools to remain viable. First, a strong federal prompt pay standard that would

apply to all payers would be a significant step forward in addressing the problem of delayed payments. Such legislation would protect both patients and physicians. The practice of delaying payment for services that have been rendered in good faith by physicians has the potential to create systemic problems—access to care and continuity of care for patients as the beneficiaries of contracts between insurers and providers—interfering with protecting the health and welfare of America's patients. For physicians, typically in a "take it or leave it" position when it comes to entering into contracts with health plans, particularly large insurers with significant market power, federal legislation would provide recourse for physicians and hold health plans to reasonable business standards.

Second, in crafting a federal legislative solution, stronger state laws must be protected. The federal standard should be a "floor," and state requirements not covered by the federal standard should not be preempted. In addition, federal prompt pay legislation should include an explicit assignment of responsibility for enforcement to a state agency. Experience has shown that enforcing these standards requires constant interaction with payers and providers, which favors continued state enforcement. For most states, the state agency responsible for enforcement would be the state department of insurance. Other states typically have their department of health involved in investigating complaints, especially those against HMOs. Thus, the appropriate agency should be required to designate a specific unit and process for handling complaints regarding late payment. In addition to a primary enforcement agency, the legislation should stipulate that the state agency shall inform the state attorney general of repeat offenders and/or particularly egregious payment practices by insurers and the law should require the attorney general to take action against such offenders.

Third, federal legislation should clarify that state prompt payment laws apply to all non-government health plans, including self-insured group health plans doing business in the state. It is within a state's right to regulate general fair business practices of entities doing business in the state, including timely payment of claims. State laws should govern timely payment practices, as payment for services rendered does not involve or prevent the administering of a benefit as defined under the Employee Retirement Income Security Act (ERISA). Prompt-payment laws have only a peripheral, indirect effect, if any, on health plan administration and do not create additional avenues for participants to enforce their rights under a plan or obtain benefits under a plan. They do not require payment for benefits that the plan deems are not covered, but merely require reasonable timeframes for paying providers for covered benefits. Moreover, there is a strong presumption against ERISA preemption where the state regulation at issue is part of its traditional authority to regulate the health and welfare of its citizens. Prompt-payment laws fall squarely within this category, as they are designed to protect health care providers from financial distress, thus impacting their ability to provide care. Thus, any federal legislation should clarify that ERISA preemption does not apply to state prompt payment laws.

Fourth, significant penalties should also be a feature of any federal legislation addressing prompt payment of claims. Interest should be automatically assessed on unpaid claims

that have not been contested or remain unpaid without good cause. The interest rate should increase the more delinquent the payment becomes, serving as a continued disincentive to leave claims unpaid for long periods of time. In addition, reasonable attorneys' fees and costs for physicians' successful efforts to recoup unpaid claims should be provided. And to counter the common fear among physicians that taking formal action against delinquent health plans will result in retaliatory dropping from the health plan's network, any federal legislation should prohibit such actions.

Finally, federal legislation is needed to address the other strategies utilized by health insurers to delay, decrease, and/or deny payments to physicians for medical services rendered. The legislative reforms would address health plan delays based upon assertions that

- claims are not "clean claims;"
- a patient is not a covered beneficiary;
- services provided were not medically necessary or covered by the contract; or,
- the manner in which the services were accessed or provided was faulty or not consistent with the contract.

Among other things, the legislation should provide a mechanism that would improve a physicians' ability to file complete claims in accordance with health plan requirements. Health plans should also be required to notify providers within a statutorily prescribed timeframe if they are contesting a claim or if they believe a claim to be incomplete. This notification should specify all problems with the claim, and grant the opportunity to provide all additional information. Similarly, health plans should be required to pay any portion of a claim that is complete and uncontested. Such a requirement would discourage plans from finding a small defect in a large claim in an attempt to delay payment. It is also important that any federal legislative initiative cover all health carriers, including insurers, HMOs, PPOs, PSOs, and any other form of third-party payer, including all entities that pay or administer claims on behalf of other entities. As health plans sometimes deny claims that have already been adjudicated, citing various reasons for doing so, language explicitly limiting the period for retroactive denials should be part of any federal legislation. Such denials have been known to occur several years after a claim is paid and constitute a significant burden on physicians.

Conclusion

While timeliness of payment has been an important issue for physicians, there are an array of other payment issues that have contributed to the incredibly difficult climate for physicians attempting to be paid promptly, accurately and fairly by insurers. Thus, along with addressing the issue of prompt payment, efforts should be made to deal with other critical insurer payment practices. One-sided contract terms, lack of transparency or conformity in payer payment rules, repricing of physician claims, refusal to accept valid assignments of benefits, and other manipulative payment practices represent egregious business practices. These practices would be unacceptable in any other business context and should not be permitted to continue and flourish in the health insurance industry.

Statement of Dr. Robert M. Merrill
Chairman, Council on Governmental Affairs
American Association of Orthodontists
American Association of Orthodontists
Submitted to the Regulation, Healthcare and Trade Subcommittee of the
Committee on Small Business
U. S. House of Representatives
Hearing on Late Payment by Insurers
August 1, 2007

Chairman Gonzalez, Ranking Member Westmoreland, and Distinguished Members of the Subcommittee, on behalf of the American Association of Orthodontists (AAO)[1] thank you for your leadership in holding this important hearing to address issues related to the late payment of benefits by insurers. As the current Chairman of the association's Council on Government Affairs (COGA), it is my honor to have the opportunity to share the experiences and perspectives of its member orthodontists as the Committee considers ways to alleviate the problems caused by the late payment of benefits.

Orthodontists are uniquely qualified and educated dental specialists who correct improperly aligned teeth and jaws. There are currently 9,200 U.S. members in the AAO, and applicants must meet the following criteria for membership: (1) complete the full curriculum of an ADA accredited dental school, plus at least two academic years of an accredited/advanced specialty training in orthodontics; (2) practice solely in the area of orthodontics or be employed full-time by an accredited academic program; (3) be a member in good standing of the American Dental Association; and (4) adhere to the *Principles of Ethics* of the AAO.

Orthodontics is one of America's finest examples of a thriving small business community. The nation's orthodontists, over 75% of whom are solo practitioners that employ an average of seven dental service professionals, currently provide care to an estimated 4.4 million adolescents and over 1 million adults.[2] Just over 60% of patients nationwide have insurance coverage that includes an orthodontic benefit to one degree or another. In my own office approximately 55% of our active patients have orthodontic insurance benefits. The average benefit is about a $1,500 lifetime maximum benefit for a $6,000 orthodontic treatment and retention fee. Insurance benefits range from $500 to $2,000 for families treated in my office. The best insurance companies pay claims within thirty days, not unlike the best patients who also are prompt in paying their bills so that we do not have to send out multiple statements requesting payment. With electronic

[1] Founded in 1900, the American Association of Orthodontists (AAO) is the oldest and largest dental specialty professional association in North America. The AAO is dedicated to advancing the art and science of orthodontics and dentofacial orthopedics, improving the health of the public by promoting quality orthodontic care, and supporting the successful practice of orthodontics.

[2] According to internal surveys.

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filing of insurance claims it should be reasonable to expect payment within two weeks for routine claims.

The average orthodontic practice is often hard-hit by economic downturns, as families often defer what may be perceived as elective orthodontic treatment. The result is that orthodontic practices have the second lowest profit margins among dentists and all of the dental specialties, making it difficult to sustain orthodontic practices in underserved or rural communities. Often underscoring these financial difficulties is the practice of insurance companies that delay payment to orthodontic practices and thus cause additional hardship for both the practice and its patients. Waiting on timely and complete payment from insurance providers often negatively impacts the critical cash flow of small business medical professionals like orthodontists.

As health care providers, orthodontists care about the quality of treatment of their patients and have a personal interest in the success of treatment. Orthodontists are typically very involved with the community and develop long-lasting relationships with their patients, as treatment often takes years from the first visit to completion.

Since there are a relatively small number of orthodontists nationwide, with the total number of practices at less than 9,000, we believe it is likely that insurance companies view the practices as "lightweights" that can be "moved to the back of the line" when it comes to payment of benefits. In short, this issue is about fairness as it involves large, powerful insurance companies and their relationship to small, community-based health care providers and their patients.

I'd like to describe five ways in which late payment of benefits by insurers specifically harms the average orthodontic practice, a system used by one insurer that works well in my private practice, and outline several areas where legislation could potentially help:

1. ***Cash Flow Problems.*** As small businesses, it is important to keep a steady and consistent cash flow in order to pay salaries of employees, vendors and to upgrade equipment in order to provide the best, most technologically advanced care possible to patients. I always want to do what is best for my patients and focus my attention on them. Late payments by insurers complicate cash flow, thus causing numerous accounting problems that require additional time, resources and staff to alleviate. This ultimately can distract me from patients. I'm a small businessman – like virtually all of my orthodontic colleagues across the country. We all have to keep the business running well if we are to provide the best patient care of which we are capable. We have payrolls to meet and bills to pay every month and the slow rate of repayment complicates our business operations.

2. ***Increased Burden on Patients.*** Many orthodontists in recent years have simply stopped processing insurance claims, since the cost of hiring additional administrative staff to comply with insurance company "red-tape" outweighs the benefit they receive in return. My brother-in-law was one such orthodontist and he practices in Oak Harbor, Washington, having been in business since 1984. He has a moderately sized practice and has the opportunity to work with many children of the men and women of our armed forces who are stationed at the Oak Harbor Naval Air Station. He determined that he would need another full time

staff person in order to complete and follow up on the insurance claims for all of his patients, and he was unwilling to shift this additional cost onto his patients through increased fees for treatment. Regrettably, this causes additional strain for the patient, who is then burdened with the task of completing complicated reimbursement forms and communicating with insurance companies.

3. ***Administrative Costs.*** As with other sectors of the health care industry, higher costs of insurance company compliance results in the overall cost of patient care being increased. Many of the nation's orthodontists who have long-standing practices report that insurance company benefits for orthodontic treatment have remain unchanged for over 20 years. Because insurance company benefit amounts have in many cases remain unchanged, this means that even patients who are covered by insurance often bear the entire burden of increased health care costs. The fact is that access to quality orthodontic care suffers when practices devote additional resources to recovering late insurance payments.

4. ***Non-Duplication of Benefits.*** A related issue that affects orthodontists is what is termed non-duplication of benefits. This means that patients are covered by more than one insurance policy, yet the second policy will refuse to make any payment on behalf of the patient. It may be that be both parents or a parent and a step-parent are employed and have paid the premiums for insurance that includes orthodontic coverage, yet will be unable to receive the benefit because of a non-duplication clause in the insurance policy. I can tell you that this has happened many times in my office and in numerous orthodontic offices throughout the country. In these cases, patients with dual coverage sometimes end up in a paradox that costs valuable time and resources to resolve. Oftentimes, it appears that insurance companies dispute their liability in these cases as a matter of policy, and the resulting time and effort to resolve the dispute costs everyone but the insurance company money. This also means that the employee who happens to have insurance coverage through a spouse cannot access their benefits equally to an employee working for the same company who is not covered by another insurance plan, even though they are both paying the same premium. This situation is unfair to these people who are paying for a benefit and not receiving it. This needs to be remedied. Therefore, the AAO believes that consumers who pay for insurance coverage should get the full extent of the coverage they are paying for instead of getting caught in a tangled maze of paperwork that ends with a denial of payment by a second provider. Congress should require that where families have multiple dental benefits plans, each plan will pay a portion of the dental care claim according to their contracted scope of benefits, not to exceed 100% of the amount of the claim.

5. ***Coordination of Benefits.*** The treatment fee is such that both plans will end up paying their maximum, but the secondary insurer will refuse payment until a primary Estimate of Benefits (EOB) is received, causing additional payment delays and increased paperwork and expense for office and insurance company alike. At times it takes up to three months to get the secondary payment.

6. ***Emulating Effective Repayment Systems***

Insurance payment systems that work best for my office are the ones that pay automatically once the initial billing has been received. This cuts down on expense and increased work hours for both the orthodontic office and insurance company. Companies that utilize an automatic payment plan with two or three payments work best. For example, half the benefit payment is made at the beginning of treatment and the second half of the insurance company benefit is paid six months later instead of with smaller monthly automatic payments. Manual monthly insurance billing is very time consuming and adds to the administrative expense for both the practice and the insurance company. This ultimately costs the patient more.

The AAO appreciates the opportunity to share the experiences and perspectives of our member orthodontists as the Committee considers ways to alleviate the problems caused by the late payment of benefits. I hope that the testimony I have offered has been valuable to that end and I hope that if the AAO can be of any further assistance to this committee you would not hesitate to call upon us. As we work together, we can improve the opportunities for small businesses throughout the country and help improve access to quality orthodontic care for our nation's citizens. I consider it an honor to have been able to offer testimony to this committee and would be pleased to entertain any questions you may have for me as the representative of the American Association of Orthodontists.

Submitted by:

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Chair, Council on Governmental Affairs
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Information concerning prompt pay (no pay) of professional medical services

Provided by
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Provided to Chairman Charles Gonzalez and Members of the House Small Business Committee, Subcommittee on Regulations, Health Care and Trade

August 1, 2007

Hearing: "*Ensuring Prompt Payment for Small Health Care Providers*" on Wednesday, August 1, 2007 at 10am in Room 2360 of the Rayburn House Office Building

Overall there has been improvement in Texas due to the prompt pay laws passed in 2003 (SB418). Many insurance companies have taken measures to improve claims processing and payment for those lines of service that are clearly subject to state regulation. There are still some bad actors, however. On 12/19/05, United Healthcare of Texas was fined $ 4,000,000 by the Texas Department of Insurance for violation of Texas prompt pay laws.(Attachment 1) In fact, according to the TDI Order, the last independent auditor report on their payment practices is due August 15. However, as more and more insurance business moves to self-funded arrangements, any ambiguity in authority to regulate becomes significant. The majority of the prompt pay laws relate to payment of clean claims but there are other ways insurance companies are able to get away with slow pay, low pay, or no pay.

Slow pay, low pay, or no pay has a huge impact on small physician practices and patients. Our pathology group services the Christus Santa Rosa Centre City Hospital in San Antonio. This hospital has a very high Medicare and indigent care population. The Children's Hospital is on the same campus and has a very high Medicaid and indigent population. The Children's Hospital is a tertiary teaching hospital with children's cancer and heart surgery

programs affiliated with the University Of Texas Health Science Center at San Antonio (UTHSCSA). Our pathology group is a private practice and is not financially supported by the UTHSCSA. Due to the complicated patients in our hospital practice, we must have a high level of pediatric and oncological specialized pathology services as well as general clinical and anatomic pathology services. These programs are difficult to provide in a financial environment of high Medicare, Medicare and indigent care populations. We need appropriate and timely payments from insurance payers to provide pathology services these patients require.

The market conduct and payment practices of large ERISA plans as it relates to their interaction with small physician practices are unregulated. The Department of Labor does not believe that ERISA addresses payments owed to physicians. The Department of Labor's regulations in the words of the agency do "not apply to requests by health care providers for payments due them -- rather than due the claimant -- in accordance with contractual arrangements between the provider and an insurer" Despite this statement by the federal government, state regulatory agencies, because of the very broad language in the ERISA law that preempts state regulation, are extremely reluctant to devote resources to addressing an area where the law

lacks clarity. In other words, there is a considerable absence of oversight in an area that every state in the Union has deemed important enough to regulate where there is no ambiguity over authority.

Most pathologists are trained and boarded by the American Board of Pathology. Most pathologists enter residency training programs with extensive training in both Anatomic and Clinical Pathology. These are two separate boards a pathologist may take. Clinical pathology deals with the professional medical direction and oversight of medical laboratories. A person with this level of training is required by the federal government through the Clinical Laboratory Improvement Act (CLIA) to be medical director of the laboratory. In Texas, the Attorney General has recognized the medical direction of the clinical laboratory as the "practice of medicine". Anatomic pathology is a separate board that deals with the interpretation of tissues procured through biopsies, surgery, scrapings, or autopsy.

Consider the following example from my practice. Since 2004, we have had problems with UnitedHealthcare concerning slow pay/ low pay/no pay for specialized clinical pathology services. Prior to that time, UHC had paid for these claims on an item for item basis. UnitedHealthcare (UHC) issued a

letter to providers stating "claims system enhancements" were occurring and the update would not reimburse a professional component -26 for medical direction of the laboratory. The letter stated "exceptions would apply 1) only for pathologists with provisions in their contracts, which currently mandate payment for these services, or 2) where state mandates require a pathologist to be reimbursed for the supervision of hospital lab by reporting a 26 modifier for these codes." They stated that these services were "covered" but that the payment was to be made to the hospital and the pathologist should look to the hospital for payment of these services.

Professional clinical medical laboratory services require approximately 25 to 35 % of the hospital based pathologist's time. A partial list of laboratory professional medical tasks (clinical pathology professional services (CPPS)) is included in Appendix 2.

PASA made several attempts to contact UHC after the letter to determine if we were an "exception" in the letter since our contract with UHC specifically included payment for clinical pathology professional services (CPPS) and in Texas there is a prohibition on the corporate practice of medicine that requires the pathologists to be reimbursed for the supervision

of the hospital laboratory. It was also pointed out to UHC that hospitals denied receiving payment for these services and that hospital contracts had not been modified to reflect these changes nor did hospitals receive an increase to pay pathologists for these services.

In the fall of 2004, PASA began to receive denials for payment of CPPS. We made several good faith attempts to work out a solution and resolve the issue personally and through the Texas Society of Pathologists (TSP), the Texas Medical Association (TMA), the American Medical Association (AMA) and the College of American Pathologists (CAP).

In the ensuing discussions, UHC's position has been elusive and evasive. They first said they were following the Medicare model and that these services were recognized covered services but the payment was to the hospital and the pathologist should seek payment from the hospital. It was pointed out to them that while it is true Medicare pays for these services to the hospital through Part A DRG payments, Medicare is a federal program that can trump state laws and is not an private insurance product. It was further pointed out that Medicare does recognize these as professional physician services and actually requires the oversight to be in compliance

with the Clinical Laboratory Improvement Act. In addition, the payment directly to the pathologists by non-federal insurance is supported by the TMA and the CPT coding system.

UHC then changed their stance and said they would pay pathologists for these services but only by increasing the payment for anatomic pathology professional services (APPS). This method calls to question ethical considerations since only about 15 to 20% of hospital patients have APPS and 60 to 70% of patients have CPPS (Attachment 3). Even though APPS are considerably higher than CPPS and usually account for about 70% of a hospital based pathologists' income, a patient with only APPS would be unfairly paying the bill for a patient that only had CPPS.

Finally, PASA with the help of TMA complained to the Texas Department of Insurance. In the letter of April 6, 2006, UHC shifted position once again and wrongfully states on page 4 paragraph 2; "Moreover, UnitedHealthcare- just like the federal government- does not recognize that there is any professional component for those services". The fact is the federal government does recognize CPPS as does TMA, AMA, CAP and the CPT coding system. In the same letter, they state the Texas prohibition against the

corporate practice of medicine "is not strictly relevant". They also imply that ERISA plans may not be affected since the majority of the claims at issue were processed by UHC on behalf of self funded employee benefit plans and UHC would have to do further research on the funding sources.

In addition to requiring prompt payment – according to contract - Texas prompt payment laws (SB418 2003) mandates that the insurance company must provide, upon request, in reasonable detail an explanation of all payments for contracted services. If these payments are in fact being made to hospitals, UHC should be able to provide specific detail about these payments. TDI has not acted on these issues to date.

This demonstrates that requiring prompt payment is not enough to solve the issues facing small practices in their interaction with large insurers. A single transparent clinically based set of processing rules is necessary to see that physician claims are paid promptly *and* correctly.

Another common example of a bundling edit that illustrates the need for a standard code editing system is the situation in which a patient sees the doctor for an annual physical or, in medical terminology, a preventive

service. While the physician is conducting the annual physical examination, patients will frequently comment that they are having an acute problem. This could be a simple condition such as a cold or something more potentially serious like a mole that has changed colors. The doctor may conduct a more extensive examination (aka, evaulation and management service or E&M), perform additional diagnostic tests or perform additional procedures related to the acute problem.

There are at least 3 different methodologies that commercial health plans routinely employ to determine the amount to be paid when a physician has provided a preventive service and an E&M during the same patient encounter. The health plan may refuse to pay for one of the services rationalizing that the additional care is not separately payable. The health plan may pay for both services but require the physician to provide documentation of the additional care provided. At least one health plan will pay for only 50% of the cost to provide the additional care.

One way that this problem can be dealt with is the physician will choose to treat the acute problem and ask the patient to make an appointment to return at a later time for the preventive services. However, physicians are often

reluctant to do this. Implementing this type of policy would require patients to postpone needed preventive care, take additional time away from work or family, and/or pay an additional office visit co-payment. Physicians are caught between providing quality health care to their patients or providing necessary services that will go unpaid – merely because of the way the claim is processed.

Let us keep in mind what underlies these practices. In 2004, UHC CEO Bill McGuire made $36,998,014. The StarTribune in Minneapolis-St.Paul said in a April 21, 2006 article - *"Dollar Bill" has made lots of news with cash-and-stock paydays that have topped $100 million in recent years -- and he's still sitting atop stock options valued at $1.6 billion. McGuire's admiring outside board members -- 10 of whom have become millionaires through the sale of their own appreciated stock in recent years -- have defended his league-leading compensation on grounds that the giant health insurer's stock price has been a superb performer*

This compensation comes from the businesses that pay for coverage and is delivered elsewhere rather than for the intended health care.

PASA has since terminated our contract with UHC and we are currently in a class action arbitration. The sad part of the story is that PASA out of network will mostly hurt the patients since they are the ones that will have to pay increased out of network costs to access the specialty pathology services of Christus Santa Rosa Health Care in San Antonio.

In summary, I believe additional federal laws are necessary to help providers and patients against billion dollar insurance companies with legions of lawyers to obscure legal issues. These laws can be patterned after state laws on prompt pay or they can mandate state regulation of ERISA plan activity in a manner similar to the state's current prompt pay statutes. I believe it is good public policy make sure ERISA plans are regulated and that they actually pay for the care they have promised to cover on behalf of my patients and their employers. In addition, I suggest the following recommendations:

1) Insurance companies must state whether disputed services are "covered" or "noncovered", not recognized or non recognized.

2) If a service is covered, mandate that there must be a payment for the service.

3) Insurance companies should not be allowed to increase payment for one service to cover a lesser payment for

another unless specifically agreed to otherwise by both parties in a written contract. The payment for each covered service should be on an item for item basis.

4) Payment to someone other than the provider, or a person authorized by the provider for reassignment, should be prohibited.

5) The subcommittee should consider a single set of rules on claims processing by all insurance companies that is clinically based so there is transparency in the claims processing system.

6) In cases of dispute requiring arbitration, the insurance company should pay the majority of the arbitration costs.

7) Contracts should not have provisions deterring class action arbitration or litigation.

No. 05-1073

OFFICE
of the
COMMISSIONER OF INSURANCE
of the
STATE OF TEXAS
AUSTIN, TEXAS

Date: DEC 19 2005

Subject Considered:

UNITED HEALTHCARE INSURANCE COMPANY
450 Columbus Blvd.
Hartford, Connecticut 06115-0450

UNITED HEALTHCARE OF TEXAS, INC.
5800 Granite Parkway
Plano, Texas 75024

CONSENT ORDER
DISCIPLINARY ACTION

General remarks and official action taken:

On this date came on for consideration by the Commissioner of Insurance, the matter of whether administrative action should be taken against United Healthcare Insurance Company ("UHIC"), Hartford, Connecticut, and United Healthcare of Texas, Inc. ("UHT"), Plano, Texas. The Texas Department of Insurance ("TDI"/"Department") alleges that UHIC and UHT have violated the insurance laws of the State of Texas relating to compliance with Texas prompt payment statutes and rules with particular reference to affirmatively adjudicated pharmacy claims, the reporting required with respect to the prompt payment of claims, and the proper maintenance of complaint records and complaint logs. TDI alleges that such conduct constitutes grounds for the imposition of sanctions against UHIC and UHT pursuant to TEX. INS. CODE ANN. §§ 84.021 — 84.022.

The parties, by their respective signatures hereto, announce that they have compromised and settled all claims and agree, pursuant to TEX. INS. CODE ANN. § 82.055, to the entry of this Consent Order. The parties request the Commissioner of Insurance to informally dispose of this case pursuant to the provisions of TEX. GOV'T CODE ANN. § 2001.056, TEX. INS. CODE ANN. §§ 36.104 and 82.055, and 28 TEX. ADMIN. CODE § 1.47.

WAIVER

UHIC and UHT acknowledge the existence of their rights regarding the entry of this Order to a notice of hearing, a public hearing, a proposal for decision, rehearing by the Commissioner of Insurance, and judicial review of the Order as provided for in TEX. GOV'T CODE ANN. §§ 2001.051 — 2001.178, and hereby expressly waive each and every one of said rights and acknowledge the jurisdiction of the Commissioner of Insurance over them. UHIC and UHT further acknowledge that they have been made aware of the nature of their alleged violations and the extent of potentially applicable sanctions which such violations may merit.

JURISDICTION

The Commissioner of Insurance has authority and jurisdiction in this matter pursuant to 28 TEX. ADMIN. CODE §§ 11.205(a)(20), 21.2504, 21.2807, 21.2821 and 21.2822, TEX. INS. CODE ANN. §§ 38.001, 82.051 - 82.055, 84.021 - 84.044, 542.003(b), 542.005, 801.051 – 801.053, 843.260, 843.338, 843.339, 1301.103 and 1301.104, and TEX. GOV'T CODE ANN. §§ 2001.051 - 2001.178. The parties request that the Commissioner of Insurance enter this Order in accordance with the law applicable to the facts.

FINDINGS OF FACT

The Commissioner of Insurance makes the following findings of fact:

1. UHIC is a foreign life and health insurance company domiciled in the State of Connecticut and currently holds a Certificate of Authority issued by the Department.

2. UHT is a domestic health maintenance organization which currently holds a Certificate of Authority issued by the Department.

3. In conjunction with entry of this Order, and as a part of this disposition of this matter, the Department is also granting in a separate order on this day the request of UnitedHealth Group Incorporated to acquire the licensed Texas domestic health maintenance organization, Pacificare of Texas, Inc., and Pacificare Life Assurance Company, a Colorado domestic insurer, commercially domiciled in Texas.

Prompt Payment Compliance

4. Claims payment information and data provided to the Department in response to Commissioner Orders Nos. B-0004-04, B-0018-04, B-0029-04, B-0042-04, B-0003-05, B-0017-05, B-0028-05, and B-0066-05 demonstrate that UHIC and UHT failed to pay certain clean claims in accordance with the Texas prompt payment statutes and rules: TEX. INS. CODE ANN. §§ 843.338, 843.339,

05-1073

1301.103 and 1301.104 and 28 TEX. ADMIN. CODE §§ 21.2807 and 21.2822. Due principally to the processing of affirmatively adjudicated pharmacy claims, UHIC and UHT failed to meet the 98 percent prompt payment compliance standard as required by 28 TEX. ADMIN. CODE § 21.2822(a) for the period beginning January 1, 2004, through March 31, 2005.

Reporting with Respect to Prompt Payment of Claims

5. UHIC and UHT failed to accurately report to TDI their claims payment information required pursuant to 28 TEX. ADMIN. CODE § 21.2821 with respect to calendar year 2004 and the first three quarters of 2005. UHIC and UHT allege that subsequent information provided to the Department, which updated the provider claims data reports, indicates that UHIC and UHT achieved the 98 percent compliance standard for the applicable time period.

Complaint Record and Complaint Log Issues

6. Review by TDI of UHIC and UHT internal complaint records and complaint logs for 2004 and part of 2005, maintained pursuant to TEX. INS. CODE ANN. §§ 542.003(b), 542.005, 843.260, and 28 TEX. ADMIN. CODE § 21.2503, revealed that such complaint records and complaint logs were deficient in that the function, reason, disposition, and/or date of disposition fields were not accurately entered in the complaint records and complaint logs for all complaints, as required by 28 TEX. ADMIN. CODE §§ 11.205 (a)(20) and 21.2504 (c), (e), and (g).

Resolution

7. UHIC, UHT, and TDI agree that an appropriate disposition of this case is the payment of an administrative penalty and full compliance with the following:

UHIC and UHT agree to the following terms and conditions of this Order:

(a) UHIC and UHT shall pay in the aggregate an administrative penalty in the amount of Four Million Dollars ($4,000,000.00) within thirty (30) days from the date of this Order. This administrative penalty includes:

(i) Two Million Five Hundred Thousand Dollars ($2,500,000.00) for alleged failure to pay clean claims, with particular reference to affirmatively adjudicated pharmacy claims in accordance with the 98 percent prompt payment compliance standard as required by Texas prompt payment statutes and rules.

(ii) One Million Five Hundred Thousand Dollars ($1,500,000.00) for alleged failure to file accurate and complete provider claims data

reports, and alleged failure to maintain accurate and complete complaint records and complaint logs.

(b) UHIC and UHT shall process clean claims in accordance with Texas prompt payment statutes and rules and maintain a 98 percent or higher prompt payment compliance standard each quarter, as required by TEX. INS. CODE ANN. §§ 843.338, 843.339, 1301.103 and 1301.104 and 28 TEX. ADMIN. CODE §§ 21.2807 and 21.2822(a).

(c) UHIC and UHT agree that in addition to the above penalty, UHIC and UHT shall pay additional penalties should the companies in the aggregate fail to achieve a 98 percent prompt payment compliance standard with respect to clean claims from all physicians and providers in each quarter during the period January 2006 through June 2007. The additional penalties shall be calculated as follows: in the event UHIC and UHT, on an aggregate basis, fail to maintain such 98 percent or higher prompt pay compliance standard each quarter, as required by TEX. INS. CODE ANN. §§ 843.338, 843.339, 1301.103 and 1301.104 and 28 TEX. ADMIN. CODE §§ 21.2807 and 21.2822(a), they shall pay an additional penalty of Three Million Dollars ($3,000,000.00) for each and every quarter that the companies are non-compliant, beginning January 2006 through June 2007.

(d) UHIC and UHT each agree to submit to a verification of their compliance with Texas prompt pay statutes and rules by an independent certified public accountant ("auditor"). Such auditor will be chosen and paid for by UHIC and UHT, but such selection and engagement will be subject to the approval of the Department. UHIC and UHT shall submit a proposed auditor to TDI within sixty (60) days of the date of this Order. The auditor shall be required to provide a verification report to TDI on or before June 30, 2006, regarding the accuracy and completeness of the quarterly prompt pay reports filed with the Department by UHIC and UHT for the period of January 1, 2006, through March 31, 2006. If the reports filed by the companies are found by the auditor to not be accurate, the auditor shall provide a written verification report as to the different results derived by the auditor using generally accepted auditing standards.

The auditor shall provide a second such verification report on or before August 15, 2006, regarding the reports filed with the Department for the period of April 1, 2006, through June 30, 2006.

The auditor shall provide a third such verification report on or before May 15, 2007, regarding the reports filed with the Department for the period of July 1, 2006, through December 31, 2006.

The auditor shall provide a fourth such verification report on or before August 15, 2007, regarding the reports filed with the Department for the period of January 1, 2007, through June 30, 2007.

(e) The above verification reports shall verify that the auditor used applicable, generally accepted auditing standards. The auditor's work papers shall be made available to TDI upon request. Subject to Finding of Fact No. 8 hereof, such additional penalties shall be paid within thirty (30) days of the date of the Department's violation notice.

(f) UHIC and UHT agree to pay any required restitution in compliance with TEX. INS. CODE ANN. §§ 843.338 and 1301.103 and all other Texas prompt payment statutes and rules to Texas physicians and providers.

(g) UHIC and UHT shall timely file claims payment information reports with TDI that are true, correct, and complete in all material respects, as required by 28 TEX. ADMIN. CODE § 21.2821.

(h) For each calendar quarter in 2006 and 2007, UHIC and UHT shall timely file with the Department Texas complaint records that are true, correct, and complete in all material respects, as required to be maintained by TEX. INS. CODE ANN. §§ 542.003(b) and 542.005 for insurers, and complaint logs that are true, correct, and complete in all material respects, as required to be maintained by TEX. INS. CODE ANN. § 843.260 for health maintenance organizations. The complaint records and complaint logs are due on or before the 15th day of the month immediately following the conclusion of each calendar quarter, demonstrating that quarter's activity. Such reports shall be filed with Catherine Bell, Texas Department of Insurance, Enforcement Section, P.O. Box 149104, Mail Code 110-1A, Austin, Texas 78714-9104 (or her successor).

(i) UHIC and UHT agree that in addition to the above penalties, UHIC and UHT shall pay in the aggregate additional penalties should either company fail, in any material respect, to (A) timely file any quarterly report required to be filed under 28 TEX. ADMIN. CODE § 21.2821 for 2006 and 2007, or (B) maintain and timely file their complaint records and complaint logs with TDI, as required by paragraph 7 (h). The additional penalties shall be calculated as follows: For failure to comply with (A) above during calendar years 2006 and 2007, UHIC and UHT shall pay an additional penalty of One Million Five Hundred Thousand Dollars ($1,500,000.00), provided, however, the maximum penalty for such failure for the two companies combined shall not exceed the amount stated above irrespective of the number of quarters for which the report is not timely filed. For failure to comply with (B) above during calendar years 2006 and 2007, UHIC and UHT shall pay an additional

penalty of One Million Five Hundred Thousand Dollars ($1,500,000.00), provided, however, the maximum penalty for such failure for the two companies combined shall not exceed the amount stated above irrespective of the number of instances in which the complaint record or complaint log is not timely filed or properly maintained. Subject to Finding of Fact No. 8, such additional penalties shall be paid within thirty (30) days of the date of the Department's violation notice.

(j) Should a penalty become due under paragraph 7(i)(A) or (B), the following provisions shall apply: (A) the filing requirements of paragraph 7(g) or (h), as the case may be (depending on which requirement fails to be met), shall automatically be extended for an additional period of two (2) years; and (B) during the years 2008 and 2009, if UHIC and/or UHT fail, in any material respect, to comply with such extended requirement, UHIC and UHT shall pay additional penalties as follows: with respect to the clean claims reporting requirement (if that requirement is extended), UHIC and UHT shall pay an additional penalty of Three Million Dollars ($3,000,000.00), provided, the maximum penalty for the two companies combined shall not exceed the amount stated above irrespective of the number of instances in which the report is not timely filed; and with respect to the complaint record or complaint log requirement (if that requirement is extended), UHIC and UHT shall pay an additional penalty of Three Million Dollars ($3,000,000.00), provided, the maximum penalty for the two companies combined shall not exceed the amount stated above irrespective of the number of instances in which the complaint record or complaint log is not properly maintained. Subject to Finding of Fact No. 8 below, such additional penalties shall be paid within thirty (30) days of the date of the Department's violation notice.

8. Any additional penalties due under paragraphs 7 (c), (d), (i), and (j) which become due pursuant to the terms of this Order shall be due and owed, without application of the Administrative Procedure Act. Should the Department determine that such additional penalties are due, it shall provide a violation notice to UHIC and UHT. The commissioner shall have the discretion, without recourse to the Administrative Procedure Act, to waive any portion of the above additional penalties, and the companies may request an informal meeting with the commissioner in order to present reasons why any portion of such additional penalties should be waived.

9. TDI does not waive herein any action or penalty that may be imposed for a violation of law; provided, however, that TDI waives any further action or penalty in connection with the matters addressed by this Consent Order. This order does not address violations of Texas prompt payment compliance standards occurring for dates of service after June 30, 2007, as referenced in paragraph 7 (c).

10. Pursuant to TEX. INS. CODE ANN. § 82.055(b), UHIC and UHT agree to the sanctions provided for herein with the express reservation that they do not admit to a violation of any provision of the Insurance Code or of a rule or regulation of the Department and maintain that the existence of a violation is in dispute.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Commissioner of Insurance makes the following conclusions of law:

1. The Commissioner of Insurance has authority and jurisdiction in this matter pursuant to 28 TEX. ADMIN. CODE §§ 11.205(a)(20), 21.2504, 21.2807, and 21.2821, TEX. INS. CODE ANN. §§ 38.001, 82.051 - 82.055, 84.021 - 84.044, 542.003(b), 542.005, 801.051 – 801.053, 843.260, 843.338, 843.339, 1301.103 and 1301.104, and TEX. GOV'T CODE ANN. §§ 2001.051 - 2001.178.

2. The Commissioner of Insurance has authority to informally dispose of this matter as set forth herein under TEX. INS. CODE ANN. §§ 36.104 and 82.055, TEX. GOV'T CODE ANN. § 2001.056, and 28 TEX. ADMIN. CODE § 1.47.

3. UHIC and UHT have knowingly and voluntarily waived all procedural rights to which they may have been entitled regarding the entry of this Order, including, but not limited to, notice of hearing, a public hearing, a proposal for decision, rehearing by the Commissioner of Insurance, and judicial review.

4. UHIC and UHT violated TEX. INS. CODE ANN. §§ 843.338, 843.339, 1301.103, and 1301.104 and 28 TEX. ADMIN. CODE §§ 21.2807 and 21.2822 by failing to pay clean claims timely and by failing to maintain a 98 percent prompt payment compliance standard with particular reference to affirmatively adjudicated pharmacy claims.

5. UHIC and UHT violated TEX. INS. CODE ANN. § 38.001 and 28 TEX. ADMIN. CODE § 21.2821 by failing to file complete and accurate provider claim data reports requested by the TDI.

6. UHIC and UHT violated TEX. INS. CODE ANN. §§ 542.003(b), 542.005, and 843.260, and 28 TEX. ADMIN. CODE §§ 21.2504 and 11.205(a)(20) by failing to maintain complete and accurate complaint records and complaint logs.

IT IS, THEREFORE, ORDERED by the Commissioner of Insurance that United Healthcare Insurance Company and United Healthcare of Texas, Inc. shall comply with those conditions and requirements as contained in Finding of Fact No. 7 and shall pay the penalties required thereby.

05-1073

COMMISSIONER'S ORDER
United Healthcare Insurance Company and United Healthcare of Texas, Inc.
Page 8 of 10

The above administrative penalties, as applicable, must be paid by wire transfer, cashier's check or money order made payable to "State of Texas" and transmitted to the Texas Department of Insurance, Attn: Legal Services, Division 811, MC 9999, P.O. Box 149104, Austin, Texas 78714-9104.

Mike Geeslin

MIKE GEESLIN
COMMISSIONER OF INSURANCE

RECOMMENDED:

Douglas Danzeiser by SSW
Douglas Danzeiser, Staff Attorney
Texas Department of Insurance

AGREED, ACCEPTED, AND EXECUTED by United Healthcare Insurance Company, this _____ day of _____, 2005.

_____
United Healthcare Insurance Company

AGREED, ACCEPTED, AND EXECUTED by United Healthcare of Texas, Inc., this _____ day of _____, 2005.

_____
United Healthcare of Texas, Inc.

05-1073

The above administrative penalties, as applicable, must be paid by wire transfer, cashier's check or money order made payable to "State of Texas" and transmitted to the Texas Department of Insurance, Attn: Legal Services, Division 811, MC 9999, P.O. Box 149104, Austin, Texas 78714-9104.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

RECOMMENDED:

Douglas Danzeiser, Staff Attorney
Texas Department of Insurance

AGREED, ACCEPTED, AND EXECUTED by United Healthcare Insurance Company, this 19th day of December 2005.

United Healthcare Insurance Company

AGREED, ACCEPTED, AND EXECUTED by United Healthcare of Texas, Inc., this _____ day of _____, 2005.

United Healthcare of Texas, Inc.

05-1073

The above administrative penalties, as applicable, must be paid by wire transfer, cashier's check or money order made payable to "State of Texas" and transmitted to the Texas Department of Insurance, Attn: Legal Services, Division 811, MC 9999, P.O. Box 149104, Austin, Texas 78714-9104.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

RECOMMENDED:

Douglas Danzeiser, Staff Attorney
Texas Department of Insurance

AGREED, ACCEPTED, AND EXECUTED by United Healthcare Insurance Company, this _____ day of _____, 2005.

United Healthcare Insurance Company

AGREED, ACCEPTED, AND EXECUTED by United Healthcare of Texas, Inc., this 19th day of December, 2005.

United Healthcare of Texas, Inc.

05-1073

COMMISSIONER'S ORDER
United Healthcare Insurance Company and United Healthcare of Texas, Inc.
Page 9 of 10

STATE OF MN §
COUNTY OF HENNEPIN §

BEFORE ME, Lee Ann Prevost, a notary public in and for the State of MN, on this day personally appeared DAVID J. LUBBEN, known to me or proved to me through _____ to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that she/he executed the same for the purposes and consideration therein expressed, and, who being by me duly sworn, deposed as follows:

1. "My name is DAVID J. LUBBEN. I am of sound mind, capable of making this statement, and personally acquainted with the facts herein stated."

2. "I hold the office of VICE PRESIDENT. I am the authorized representative of United Healthcare Insurance Company, and I am duly authorized by said Company to execute this statement."

3. "United Healthcare Insurance Company has knowingly and voluntarily entered into this Consent Order and agrees with and consents to the issuance and service of the foregoing Consent Order by the Commissioner of Insurance."

Affiant

Given under my hand and seal of office on December 19, 2005.

(NOTARY SEAL)

LEE ANN PREVOST
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01-31-2010

Lee Ann Prevost
Notary Public, State of MN

05-1073

COMMISSIONER'S ORDER
United Healthcare Insurance Company and United Healthcare of Texas, Inc.
Page 10 of 10

STATE OF Texas §
COUNTY OF Collin §

BEFORE ME, Clara Arellano, a notary public in and for the State of Texas, on this day personally appeared Thomas J. Quirk, known to me or proved to me through Texas Driver's License 06654085 to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that she/he executed the same for the purposes and consideration therein expressed, and, who being by me duly sworn, deposed as follows:

4. "My name is Thomas J. Quirk. I am of sound mind, capable of making this statement, and personally acquainted with the facts herein stated."

5. "I hold the office of President and CEO. I am the authorized representative of United Healthcare of Texas, Inc., and I am duly authorized by said Company to execute this statement."

6. "United Healthcare of Texas, Inc., has knowingly and voluntarily entered into this Consent Order and agrees with and consents to the issuance and service of the foregoing Consent Order by the Commissioner of Insurance."

TJQ

Affiant

Given under my hand and seal of office on December 19, 2005.

(NOTARY SEAL)

Clara Arellano
Notary Public
State of Texas
My Commission Expires
MAY 26, 2008

Clara Arellano

Notary Public, State of Texas

ATTACHMENT 2

Clinical Pathology Professional Services

1) The consideration of appropriate test methodologies, instruments, reagents (agents used in laboratory testing), standards, and controls.

2) The establishment of test reference values and levels of precision, accuracy, specificity, and sensitivity.

3) The direction of laboratory technical personnel and advice to such personnel concerning testing.

4) Assurance that tests, examinations and procedures are properly performed, recorded, and reported.

5) Interactions with members of the hospital's medical staff regarding issues of laboratory operations, quality, and test availability.

6) The design of test protocols and the establishment of parameters for the performance of tests

7) Recommendations regarding appropriate follow-up diagnostic tests when appropriate.

8) The direction, performance, and evaluation of quality assurance and quality control procedures.

9) The evaluation of clinical laboratory data and the establishment of a process for review of test results prior to the issuance of patient reports.

10) The determination of the effects of medication on tests

11) The determination of the effects of other analysis on test results.

12) The effects of other disease states on test results.

13) The establishment of test turn around times.

14) The criteria for urgent applications.

15) The prioritization of testing and testing sequences.

16) The application and response of values that require immediate medical consideration.

17) The determination of formats for reporting.

18) The establishment of referral criteria for review by pathologists and subsequent examination.

19) The determination of the type of data collection and storage criteria that will be used for particular tests.

20) The prevention of overuse and improper application of tests.

21) The assurance that the hospital laboratory complies with state licensure laws, certain accreditation standards, and certain federal certification standards.

December 2, 2005

Ms. Audrey Selden
Senior Associate Commissioner
Consumer Protection Program/Physician Ombudsman
Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714

Re: TMA Concerns Regarding UnitedHealthcare and Unfair Claim Settlement Practices

Dear Ms. Selden:

Texas Medical Association and the Texas Society of Pathologists would like to bring to your attention a new claims settlement policy created and implemented by UnitedHealthcare. This policy, in effect, results in the cost of the professional component of clinical pathology services being imposed upon patients who receive only anatomical pathology services. In other words, patients who receive anatomical pathology services will pay for the physician services provided to patients receiving clinical pathology services. The out-of-pocket costs suffered by patients covered by UnitedHealthcare and receiving only anatomical pathology services will certainly increase as a result of the shifted costs.

Over one year ago, UnitedHealthcare instituted, at the national level, a policy where the carrier would not pay for the professional component of clinical pathology services. UnitedHealthcare represented the change in policy was the carrier's attempt to use the Centers for Medicare and Medicaid Services payment methodology where professional component fees are paid to the hospital in which the laboratory services are provided. However, unlike the CMS policy, UnitedHealthcare did not modify the Diagnosis Related Group weightings to ensure payment to the hospital covered the cost of inpatient care. In addition, it should be pointed out that CMS enjoys the benefits of the United States Constitution's Supremacy Clause, which pre-empts Texas' prohibition on the corporate practice of medicine. UnitedHealthcare does not have the authority granted by the Supremacy Clause to circumvent the corporate practice prohibition by a change in company policy. It is our understanding that several Texas hospital chief executives informed UnitedHealthcare that their agreements with the carrier did not contemplate such payment arrangements. In any event, UnitedHealthcare insists it will not pay for the professional component on a very large number of clinical pathology services.

UnitedHealthcare has, in effect, conceded that pathologists are entitled to payment for the medical services they provide, and has informed TMA that it offered individual pathology practices a method of paying for the professional component. This method of payment attempts to estimate the total cost of the professional component from clinical pathology services for a year and then spread that cost over some of the fees for anatomical services delivered during that same year. This will mean that the cost of those anatomical pathology services will increase many times and the total cost of clinical pathology services will decrease.

The net result of this payment scheme is that a patient who receives only clinical pathology services will pay nothing for the professional services, while a patient who receives anatomical pathology services will see their out-of-pocket costs rise as they are paying for ALL professional component fees. Simply, patients who receive anatomical pathology services will be paying for services provided to other patients. Fees for the most commonly provided anatomical pathology services will increase while the vast majority of clinical pathology professional fee charges will not be included in reimbursement.

TMA and TSP believes that such a claims settlement practice is unfair, inequitable and that UnitedHealthcare's activities may not be a good faith attempt to settle the claims submitted as those terms are understood in Texas Insurance Code §512.003 (West 2006).

Physician members are aware of our concern regarding UnitedHealthcare's marketplace conduct and attempt to shift costs to anatomical pathology patients. They will likely send supporting information to you directly. If you have any questions please feel free to contact Lee Spangler or Teresa Devine at, respectfully, 370-1337 and 370-1415. Ms. Shari Rhodes is the Executive Director for the Texas Society of Pathologists and may be contacted at 512-370-1526.

TMA knows that you take your charge seriously and we respectfully urge that you review our concerns and take appropriate action.

Sincerely,

Susan M Strate MD

Susan Strate, MD
Chair, TMA Council on Socioeconomics

Yvonne Hearn MD

Yvonne Hearn, MD
President, Texas Society of Pathologists

Cc: Mike Geeslin, Commissioner, Texas Department of Insurance

House Committee on Small Business
Subcommittee on Regulation, Healthcare, and Trade

"Ensuring Prompt Payment for Small Healthcare Providers."

August 1, 2007

Statement by Gordon T. Austin, D.M.D.

Chairman Gonzalez, Ranking Member Westmoreland and members of the Committee, I deeply appreciate this opportunity to testify before you on the issue of "Ensuring Prompt Payment for Small Healthcare Providers." This is an issue of national interest and significant importance. There are currently at lest 39 different state prompt payment laws. (I have provided you with a summary of these laws.) In the complex environment of healthcare any opportunity to decrease this complexity should be acted upon.

My name is Gordon Austin, D.M.D. and I practice Oral and Maxillofacial Surgery in rural Georgia (please see the provided biography.) As an Oral and Maxillofacial Surgeon, I practice in both the hospital and office settings. As a Surgical specialty, Oral and Maxillofacial surgery bridges Medicine and Dentistry. I file both medical and dental insurance claims and I am a Medicare and Medicaid provider. I have submitted written testimony and background documentation so I will keep my remarks brief to allow as much time as possible for your questions. I come before you today not representing any organization but as a small businessman with a business issue.

There are a couple of points I would like to emphasize. As the Congressional Committee with expertise on small business, it certainly is no surprise to you that as a small business it is vital that I be paid promptly for the services I provide. Secondly, I believe action on this issue is a reasonable responsibility of the Federal government because of the interstate commerce issues involved. Although I practice in Georgia, I file claims with insurance companies across the United States. (See attached list of over 250 current insurance companies in my practice, notice the many different states involved; Illinois, Massachusetts, Kansas, Oklahoma, California, Kentucky, Wisconsin, Tennessee, Washington, Georgia and others.) A reasonable time frame for payment should be a consistent and national standard. Thirdly, will it work; is it "do able"? Currently under Georgia Dental Medicaid with the ACS and Avesis insurance companies, I can examine a patient on Tuesday, perform surgery on Thursday and have the payment directly deposited in my bank account the next Monday. If some of the Georgia Medicaid

insurance companies can do this, any 3rd party payer can, if they are so motivated. Yet I have submitted to you documentation of a recent, far too common, case of services which were provided in March that still have not been paid in August, along with a log of the phone calls and documents provided to the company. This demonstrates the unreasonable time and unnecessary expense to my office spent in resolving many claims.

Again, I thank you for this opportunity and I look forward to answering your questions.

AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

317 Massachusetts Avenue NE
Suite 100
Washington, D.C. 20002-5701
P. 202.546.4430
F. 202.546.5051

www.aaos.org/dc

Statement

of

Frank B. Kelly, MD
Chair, Communications Cabinet
American Association of Orthopaedic Surgeons
(AAOS)

on

Ensuring Prompt Payment For Healthcare Providers

Presented to the
Committee on Small Business
Subcommittee on Regulations, Healthcare and Trade
U.S. House of Representatives

August 1, 2007

Statement

of

Frank B. Kelly, MD
Chair, Communications Cabinet
American Association of Orthopaedic Surgeons

Presented to the

Committee on Small Business
Subcommittee on Regulations, Healthcare and Trade
U.S. House of Representatives

Ensuring Prompt Payment for Healthcare Providers

Good morning, Chairman Gonzalez, Ranking Member Westmoreland, and other distinguished members of the subcommittee. I am Dr. Frank Kelly and I speak to you today as a practicing orthopaedic surgeon, Director of the Forsyth Street Ambulatory Surgery Center in Macon, Georgia, and a member of the Board of Directors for the American Association of Orthopaedic Surgeons (AAOS). On behalf of the AAOS and my colleagues across the country, thank you for inviting me to testify before you today on the issue of ensuring prompt payment for healthcare providers.

Overview

In many states throughout the nation, physicians contend with the problem of delayed or incomplete payments by insurers for services rendered. Orthopaedic offices report that accurate and valid claims often remain unpaid in excess of 90 days, and frequently delay payment of larger claims by identifying minor errors in ancillary portions of the claim. As a result, these physicians and their staff spend an extraordinary amount of time and effort on reimbursement issues to the detriment of their appropriate focus: patient care.

As a practicing physician and administrator for a seven-person single specialty practice, I am deeply concerned that the federal government has not done enough to ensure that physicians are paid promptly by insurers. These delays constitute a major burden for providers, particularly those physicians in smaller practices that depend on this income to fund the day-to-day operations of a medical practice.

The AAOS supports prompt payment of uncontested claims by government agencies, insurance companies and managed care plans within a 30-day time period. We also support the prompt payment of any part of a claim that is complete and undisputed.

Background
A 2001 survey of physicians by the American Medical Association revealed that prompt payment by insurers topped the list of providers' concerns. Thirty-eight percent of the physician practices surveyed said that it takes more than 45 days on average to be paid for a clean claim. In the worst cases, physicians report average payment delays of nearly one year.

In response to these concerns from physicians nationwide, 49 states have since enacted some form of prompt payment law mandating third party payers to process claims in a reasonable time period. Still, physicians all over the country are reporting that they continue to struggle with insurers who find ways to game the system and avoid reimbursing claims within the proscribed time limits. Sixteen legislatures took up the issue in 2006, indicating that the problem persists, but most of these bills languished in committee, undoubtedly succumbing to pressure from the managed care organization (MCO) lobby.

The MCOs argue that the administrative burden of processing claims prohibits timely payment, arguing that in addition to the sheer number of claims, the time it takes to review for fraud and the ambiguity over what constitutes a clean claim makes delays understandable. However, even Medicare, the nation's largest health plan processing over 900 million claims annually, adheres to a higher standard. The Social Security Act requires accurate Medicare claims be processed within 30 days, or be subject to an interest rate currently set at 5.75%.

Prior to the enactment of the Georgia Prompt Pay law, practices like mine relied almost solely on Medicare for monthly cash flow. Many of my colleagues in states with less aggressive statutes continue to depend heavily on Medicare reimbursements and often struggle to cover expenses due to late payments from private payers. In the mean time, those insurance companies withholding payments reap profits from the interest accumulating on what essentially amounts to an interest-free loan.

Enforcement
In many cases, the lack of enforcement mechanisms built into state laws renders the protections minimally effective at best. A Pennsylvania law stating that a "licensed insurer or a managed care plan *shall pay* a clean claim submitted by a heath care provider within 45 days" offered little recourse in practice, when the Pennsylvania Superior Court determined that physicians seeking to recover monies for unpaid claims did not have a private right of action under the law (*Solomon v. United States HealthCare Systems of Pennsylvania, Inc.).* While class action suits represent an alternative course of action for these claims, the costly and time-consuming nature of such cases may further delay the proper payment of individual claims.

Even in states where insurance departments are aggressive in enforcing the law, such as Georgia, New Jersey, Ohio and Texas, physicians often still find themselves begging to be paid for their work. In a survey by the American Medical Association, physicians reported that most health plans have reduced the average of 90 to 120 days they once took to pay a claim. For the most part, however, those plans still fall outside the 15- to 45-day deadline required under state prompt-payment laws.

The AAOS supports the establishment of sanctions against carriers who have a policy or practice of late payment and believes state insurance commissioners should be held accountable for enforcement of these standards. Although many states still lack these provisions, state-leveled prompt payment fines, interest, and restitution over the past several years have totaled more than $70 million in aggregate.

Examples:

- In April of 2002, the New York State Insurance Department fined 22 health plans a total of more than $4 million for failing to comply with the state's law requiring health insurers to pay physicians' clean claims within 45 days. Repeat violators were thumped especially hard, with Oxford Health Plans penalized more than $900,000 and U.S. Healthcare fined more than $750,000.

- In New Jersey, the Department of Banking and Insurance reported that Cigna Healthcare of New Jersey failed in more than 84,000 cases over a one-year period to comply with the state's prompt- pay law, and that more than 9 times out of 10 Cigna failed to pay the mandated interest on late payments.

- A 2001 study conducted by the Louisiana State Medical Society found more than $7.3 million in overdue payments to physicians- more than one-third of which was owed to a single practice.

My home state of Georgia is fortunate to have one of the most comprehensive and effective laws governing payment for medical services. Under Chapter 24, Section 59.5 of Georgia Code Title 33,[1] insurers must process payment within 15 days of receipt of clean claims, or pay a penalty equal to 18% of the benefit due. Georgia Insurance Commissioner, John Oxendine, has been unyielding in his enforcement of the law and commitment to the state's physicians, working to ensure that large insurance companies do not take advantage of small medical practices.

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[1] § 33-24-59.5. (b)(1) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer's receipt of written proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days after such receipt mail to the insured or other person claiming payments under the plan payment for such benefits or a letter or notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim has been received by the insurer, the insurer shall then have 15 working days within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the insured or other person claiming payments under the plan the insurer's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administrates or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to 18 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

ERISA

Commissioner Oxendine's reach only extends so far under current federal law, however. Approximately half of my patients, and over 100 million throughout the U.S., are covered by self-funded insurance plans, which fall under the federal Employee Retirement Income Security Act (ERISA). Although the Court has not ruled specifically on the applicability of prompt pay laws to self-funded ERISA plans, the 2004 Supreme Court decision in *Aetna Health Inc. v. Davila* stated that these plans are exempt from state regulations. In general, only those state laws that regulate the "business" of insurance are not pre-empted by ERISA, and an employer providing benefits is not considered to be in the business of insurance. As a result, thousands of claims are slipping through the cracks in this system.

Clarifying Clean Claims

For those plans that are subject to state regulation, third-party payers often dispute claims on the basis that patient care services were not medically necessary or that the method in which health care services were accessed or made available contradicted the managed care contract. When a carrier contests a claim or delays payment because more information is needed, frequently physicians are not given notice in a timely manner. When further documentation is requested, and the physician provides the information, an insurer or health plan can further delay payment by asking for additional information or clarification. Reprocessing these claims is a time-consuming process, resulting in increased practice overhead expense.

Without a clearly defined law stipulating what constitutes a "clean claim," many MCOs are easily skirting the legal requirements for prompt payment. Citing typographical errors and other minor problems with large and otherwise clean claims, insurers can effectively delay payment for months. The solution to this problem is two-fold:

1) Implement laws and regulations detailing the elements of a clean claim.
2) Establish a reasonable time period (i.e. 30 days) within which providers must be notified of a denial and the specific reasons for the denial.

At present, state prompt payment laws vary widely and many fail to address the issue of what constitutes a clean claim. The AAOS believes insurance companies and managed care plans should notify physicians promptly if a claim is in dispute or the payer desires additional information. This notification should describe all problems with a claim and give the physician an opportunity to respond to all problems at the time of initial notification. Contracts with managed care organizations should clearly define standards for billing, deficiency notification, and timely payment of claims.

Conclusion

The American Association of Orthopaedic Surgeons supports efforts to address the issue of prompt payment at the state level, through legislative and regulatory reforms. However, progress in this area has been limited due to the aforementioned barriers to implementation and enforcement.

I am pleased to have had the opportunity to share with you my experience operating under Georgia's prompt payment law. While there is still work to be done, I believe that the state of Georgia leads the nation in the area of prompt payment policy. Given the positive impact these reforms have had on our state's healthcare system, and the many hard working physicians and small businesses within it, I am confident that this obstacle can be overcome throughout the country.

On behalf of the AAOS, I would like to thank the Chair and members of the subcommittee for your interest in and attention to this important issue facing America's physicians.

AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Position Statement

Prompt Payment of Physician Claims

Timely Payment of Uncontested Claims

Many physicians are often not paid in a timely manner for health care services rendered to patients. They and their staff must, therefore, spend an extraordinary amount of time and effort on reimbursement issues to the detriment of their appropriate focus, which is patient care. Insurance carriers and health plans unreasonably delay payments to physicians for many months, as well as arbitrarily reduce payments without proper cause. Orthopaedic offices report that accurate and valid claims may remain unpaid for more than 90 days. Many insurers also delay payment of larger claims by finding minor errors in ancillary portions of the claim.

The American Association of Orthopaedic Surgeons (AAOS) supports prompt payment of uncontested claims by government agencies, insurance companies and managed care plans within a 30-day time period. The AAOS also supports the prompt payment of any part of a claim that is complete and undisputed. Whenever possible, the AAOS encourages electronic claims submission and resolution.

Notification of Deficient Claims

Third-party payers often dispute claims on the basis that patient care services were not medically necessary or that the method in which health care services were accessed or made available contradicted the managed care contract. When a carrier contests a claim or delays payment because more information is needed, frequently physicians are not given notice in a timely manner. When further documentation is requested, and the physician provides the information, an insurer or health plan can further delay payment by asking for additional information or clarification. Reprocessing these claims is a time-consuming process, resulting in increased practice overhead expense.

The AAOS believes insurance companies and managed care plans should notify physicians promptly if a claim is in dispute or the payer desires additional information. This notification should describe all problems with a claim, and give the physician an opportunity to respond to all problems at the time of initial notification. Contracts with managed care organizations should clearly define standards for billing, deficiency notification, and timely payment of claims.

Penalties, Sanctions, and Regulatory Oversight

In an effort to alleviate problems of untimely payment, some state legislatures and insurance commissions have stepped in to assure prompt payment of claims. One common legislative proposal is the payment of a monthly or yearly interest penalty on late claims.

The AAOS urges state legislatures and insurance commissions to enact or strengthen prompt payment regulations. These regulations should address standards for claims processing and management, as well as establish sanctions against carriers who have a policy or practice of late payments. State insurance commissioners should be held accountable for enforcement of defined standards.

The AAOS urges its membership to take an active interest in prompt payment issues, and encourages the efforts of state medical societies on behalf of this issue.

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