

ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE STANDING COMMITTEE

February 26, 2001

3:20 p.m.

MEMBERS PRESENT

Representative Lisa Murkowski, Chair
Representative Kevin Meyer
Representative Pete Kott
Representative Norman Rokeberg
Representative Harry Crawford
Representative Joe Hayes

MEMBERS ABSENT

Representative Andrew Halcro, Vice Chair

COMMITTEE CALENDAR

HOUSE BILL NO. 113

"An Act relating to health care insurance payments for hospital or medical services; and providing for an effective date."

- HEARD AND HELD

HOUSE CONCURRENT RESOLUTION NO. 1

Relating to establishing a Task Force on a Statewide Comprehensive Energy Plan.

- SCHEDULED BUT NOT HEARD

HOUSE BILL NO. 81

"An Act extending the termination date of the Board of Dental Examiners."

- SCHEDULED BUT NOT HEARD

PREVIOUS ACTION

BILL: HB 113

SHORT TITLE:HEALTH CARE INSURANCE PAYMENTS

SPONSOR(S): REPRESENTATIVE(S)GREEN

Jrn-Date	Jrn-Page	Action
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02/05/01	0241	(H)	READ THE FIRST TIME - REFERRALS
02/05/01	0241	(H)	L&C, HES
02/26/01		(H)	L&C AT 3:15 PM CAPITOL 17

WITNESS REGISTER

REPRESENTATIVE JOE GREEN
Alaska State Legislature
Capitol Building, Room 403
Juneau, Alaska 99801

POSITION STATEMENT: Introduced HB 113 as the sponsor.

KEVIN JARDELL, Staff
to Representative Joe Green
Alaska State Legislature
Capitol Building, Room 403
Juneau, Alaska 99801

POSITION STATEMENT: Provided information on HB 113.

JAMES J. JORDAN, Executive Director
Alaska State Medical Association (ASMA)
4107 Laurel
Anchorage, Alaska

POSITION STATEMENT: Testified on HB 113.

MIKE HAUGEN, Executive Director
Alaska Physicians and Surgeons
4120 Laurel, Number 206
Anchorage, Alaska

POSITION STATEMENT: Testified on HB 113.

JEFF DAVIS, Executive Director
Blue Cross Blue Shield of Alaska
2550 Denali, Number 600
Anchorage, Alaska 99503

POSITION STATEMENT: Testified on HB 113.

GUY BELL, Director
Division of Retirement and Benefits
Department of Administration
P.O. Box 110203
Juneau, Alaska 99811-0203

POSITION STATEMENT: Testified on HB 113.

KATIE CAMPBELL, Life and Health Actuary
Division of Insurance

Department of Community and Economic Development (DCED)
P.O. Box 110805
Juneau, Alaska 99503-5948
POSITION STATEMENT: Testified on HB 113.

NICOLE BAGBY, Account Executive
Aetna US Healthcare
Box 91032
Seattle, WA 98111
POSITION STATEMENT: Testified in opposition to HB 113.

KATHY ODEGARD, Operations Manager
Aetna US Healthcare
Box 91032
Seattle, WA 98111
POSITION STATEMENT: Testified on HB 113.

JAMES E. BROOKS, Executive Director
Providence Anchorage Anesthesia Medical Group
3300 Providence Drive, Suite 207
Anchorage, Alaska 99508
POSITION STATEMENT: Testified in opposition to HB 113.

ACTION NARRATIVE

TAPE 01-23, SIDE A
Number 0001

CHAIR LISA MURKOWSKI called the House Labor and Commerce Standing Committee meeting to order at 3:20 p.m. Those present at the call to order included Representatives Murkowski, Kott, Rokeberg, and Crawford. Representatives Meyer and Hayes joined the meeting as it was in progress.

HB 113-HEALTH CARE INSURANCE PAYMENTS

Number 0058

CHAIR MURKOWSKI announced that the committee would hear HOUSE BILL NO. 113, "An Act relating to health care insurance payments for hospital or medical services; and providing for an effective date."

Number 0109

REPRESENTATIVE JOE GREEN, Alaska State Legislature, sponsor of HB 113, said similar bills have already been adopted by 39 other

states. According to HB 113, if a bill [of service] is filed with an insurance carrier, the insurer should have a reasonable length of time to make payment. He said the term "clean claim" is used in the bill and means that all of the conditions of the insurance carrier have been satisfied, and that there is enough information to determine it is a bill that should be paid.

REPRESENTATIVE GREEN stated that sometimes that period is extended beyond what a person might consider a reasonable timeframe. House Bill 113 outlines [a payment requirement] of 20 working days for a paper claim, and 10 [working] days for an electronic claim.

Number 0206

REPRESENTATIVE GREEN relayed that there may be a desire to modify this to calendar days rather than workdays.

REPRESENTATIVE GREEN said "we" want to try and avoid an insurance company delaying the process for some small reason. He said it could [potentially] be spread out over a long period of time to finally reach resolution and payment. This may not be intentional, but may happen because of new employees receiving the claims at the insurance company.

Number 0376

REPRESENTATIVE KOTT said he likes the bill and expressed his understanding. Only 1 of the 39 states, according to the chart [provided to committee members], has less than 30 days [as the payment deadline]. There is no state that has 10 days if a claim is filed electronically. He asked: Is Alaska trying to get "better than the average and more expeditious?" Or can "we" fall back to an average time span? He noted that most states have implemented 30 days for both types of claims. He asked for the sponsor's comments on whether this is the direction Alaska wants to take.

Number 0477

REPRESENTATIVE GREEN commented that an electronic claim can be filed and processed quickly. He said there isn't mail to deal with, so much of the extraneous days are cut out. Cutting [the time] in half is arbitrary, but it certainly should be some amount less, he said.

Number 0510

KEVIN JARDELL, Staff to Representative Joe Green, Alaska State Legislature, said the average for [payment of] a paper claim is 31.7 days across the country, and within that spectrum, HB 113 is well represented. Six states have enacted separate deadlines for the electronic clean claims, as opposed to paper claims; those states are Colorado, Hawaii, Louisiana, New Jersey, New Mexico, and Texas. He added that Hawaii has a 15-day turnaround on electronic claims, and said it is working [just fine].

MR. JARDELL explained that the idea of setting a different time [frame] for electronic claims is something that is being looked at on the federal level, as an inducement to get medical professionals and providers to switch to the electronic form. It is not meant to be a detriment to the insurance companies, he said, but more of an inducement for the doctors. He pointed out that most of the insurance companies are heavily promoting electronic filing. However, it is "our" understanding that some of the doctors are resistant to this idea. This gives a shorter timeframe for turnaround of money, and a decrease in the overall administrative cost with insurance companies.

Number 0577

MR. JARDELL said 15 days isn't the norm, but it is being done.

Number 0622

REPRESENTATIVE KOTT said his concern is that if Alaska goes to 10 days for electronic filing, Alaska will have set the standard for the most expeditious filing of the 40 states. He asked what the average is for filing paper and electronic claims.

Number 0657

MR. JARDELL replied that he doesn't have the average, but Colorado's electronic claim submission in is 30 calendar days, Hawaii's is 15, Louisiana's is 25, New Jersey's is 30, New Mexico's is 30, and Texas's is 21 days. He said it leans toward 30 days, but noted that Hawaii and Louisiana have gone to a lower standard. He pointed out that 10 working days would be about 15 [calendar days], which is what he thought Representative Green was saying. He reiterated that this was an inducement to try to lower insurance payments.

MR. JARDELL stated that there are mixed thoughts about whether this poses a problem. He said maybe there is some testimony,

which could ferret out a more proper and exact timeframe. He said depending on whom one talks to, one gets different answers because some [companies] have more advanced computer systems. Apparently, there are some systems that treat [claims] the same, whether they are electronic and so forth; each insurance company has different comments to make on that [issue].

Number 0750

REPRESENTATIVE ROKEBERG asked for confirmation of his understanding of the current statute, that it might be 30 working days, but may be permissive.

MR. JARDELL said he reads the statute to be permissive. He referred to the phrase, "and upon the request of the covered person shall ... be a separate issue." This deals with the insurance company having to pay the provider following the 30-day requirement. He said he thinks most insurance companies read that as being mandatory; however, he referred to the regulations under [3 AAC] 26.040 where a company has 10 days to identify who will be handling the claim, the name of the person, and the phone number where he or she can be reached.

MR. JARDELL continued by saying that under [3 AAC] 26.070 there is a 15-day notice requirement, requiring the insurance company to give notice again, stating whether or not it is going to accept or deny the claim, and declaring how much more time it will need. Then, under [3 AAC 26.] 070, there is a 30-day notice requirement that says the claim has to be paid within 30 days if it's complete. Under [3 AAC 26.] 050 there is a 30-day notice requirement, which is separate. It says one must give notification, stating the reason for [needing] the additional investigative time. Then, under [3 AAC 26.] 070 again, there is a 45-working day period once additional investigative time has been requested before [the company] has to notify again that more investigative time is needed, which would be another 45 working days; this can total about 18 weeks.

MR. JARDELL said even at that point, there is no closure if a company still needs time to investigate the claim; a company only has to provide notice every 45 days after that.

Number 0883

MR. JARDELL said the regulation scheme is somewhat complicated. One will hear that some [of the insurance companies] are not fully complying with the regulations as they are currently

written, because they are onerous and there are so many notice requirements. He believed the intent of this legislation was to have a 30-working-day period to end the claims, which is not what is [currently] happening.

Number 0919

REPRESENTATIVE HAYES began by declaring a conflict of interest because he works in the insurance field. He checked his understanding that this legislation says that a claim has to be done, from start to finish, in six weeks.

Number 0967

REPRESENTATIVE GREEN clarified that this bill addresses only clean claims, so if there is controversy over what information is needed, the clock isn't running. He said this bill is to get around the problem with the current regulations. He emphasized that this only applies to non-controversial claims.

Number 1006

CHAIR MURKOWSKI verified that there is another notice [time] period for claims that are not clean.

REPRESENTATIVE KOTT said a company has to pay an interest rate penalty if it doesn't comply. He asked if an insurance company could circumvent the system to get around processing a clean claim within 20 days.

Number 1079

MR. JARDELL replied that the bill is set up for a company to pay a claim within 20 days or incur interest penalties until payment is made. A company can, within the 20 days, notify the provider as to why it is not a clean claim. At that point the provider must send the insurance company the additional information required to make it a clean claim. If everything requested is not provided, it still isn't a clean claim. If the information is provided, it is considered a clean claim, and the clock begins to tick again.

Number 1171

REPRESENTATIVE GREEN said if a company comes up with something 29 days later, for example, then there is a conflict.

MR. JARDELL explained that if "bad faith actions" become a pattern, those are handled through the Division of Insurance. There are actions [pursued] to take away the company's ability to sell insurance in the state. After the 20-day period, if the insurer receives the information, [the insurer] has five working days to make a payment or to deny the claim; there is finite resolution once [the insurer] gets that information. If a company comes back and says that the information wasn't exactly what it was looking for, and so forth, at that point, one would have to go to the Division of Insurance and ask the division to investigate.

Number 1239

CHAIR MURKOWSKI asked what the rationale was for setting the interest rate as outlined in [AS] 06.40 [page 2, lines 9-11, of HB 113], rather than [using] the legal rate of interest.

MR. JARDELL replied that it was appropriate to charge the same interest rate that the insurance companies charge individuals to finance insurance premiums. In looking at the chart of other states that have it, there are a number of different interest payment rates. Generally, rates are between 12 and 18 percent; 15 percent was thought to be a good tie-in to the other rates that a company charges.

MR. JARDELL said the legal rate is 10.5 percent, unless otherwise specified in the contract. Prejudgment interest is now a floating rate based upon (indisc.).

Number 1323

CHAIR MURKOWSKI asked if insurance companies are currently doing reporting.

MR. JARDELL said he understood that companies file a quarterly report to the state, and this would just add one feature to that. This is not adding an administrative burden to the companies, he said, because it is currently being done.

CHAIR MURKOWSKI referred to page 2, Section 1, lines 23-25 [of HB 113]. She said this language seemed out of order, and asked why it was in the bill.

Number 1392

MR. JARDELL replied that it is current law and has always been in the statute.

MR. JARDELL, responding to a question about whether "working days" is defined in statute, said it is, and has always been used by the Division of Insurance. He said "we" certainly don't have a problem going to calendar days if it is more acceptable to the insurance companies. He understood that with some of the programs that companies use, it is easier to calculate a calendar day, rather than recalculating each state's holidays and so forth.

Number 1467

REPRESENTATIVE ROKEBERG referred to page 2, lines 23-25. He said, "This policy referring to (a) (b) (c) and (d) above may not contain provisions requiring that services be provided by a particular hospital or person, except as applicable under an [human maintenance organization] HMO [AS] 21.86." He said AS 21.86 is the HMO chapter that this legislature has sought to make inoperable, to make it so there wouldn't ever be HMOs. He said Alaska has preferred-provider plans. He asked why this language was in the bill.

MR. JARDELL responded that it is current law.

Number 1526

REPRESENTATIVE MEYER said it seems that people are always trying to get claims in before the end of the year so they don't have to worry about next year's deductible. He asked if there is a provision whereby if an insurance company gets overwhelmed at the end of the year, it can go past the [time limit set in statute].

MR. JARDELL responded that companies are held to the same standard all year round; based on history, companies should be equipped to anticipate the increased claims and deal with them in a timely fashion. He said most companies would claim that they do pay within a reasonable amount of time, although he didn't want to speak for them.

Number 1608

JAMES J. JORDAN, Executive Director, Alaska State Medical Association (ASMA), relayed that [ASMA] had already provided some brief written testimony by Peter Lawrason, President, ASMA.

He said the timeliness of group health insurance claim payments has been an ongoing issue since he began with the ASMA 4.5 years ago. In the spring of 1998, U.S. Senator Frank Murkowski asked the ASMA to conduct a survey of private practice physicians in Alaska to look at Medicare access issues. He said as long as the ASMA was going to do the survey, it included some additional questions about timeliness of group health insurance claims; up to this point, all that was heard was just anecdotal information from the doctors.

MR. JORDAN said the survey was not extremely scientific nor were the results statistically validated. However, the results serve to indicate the feeling of the medical community. He said 950 surveys [were distributed], and the response rate was 19 percent.

Number 1768

MR. JORDAN said the results showed that Medicaid does a pretty good job. Regarding private health insurers, the average [days for payment] was 36, which, at that time, corresponded to the top nine health insurers in the state. Medicaid "brought up the rear" at 41 [days]. The data for the slowest-paying health insurers was 79 days; the shortest turnaround time was 30 days, and the longest was 365 days. He pointed out that the data is three years old, and [the situation] may have changed since then.

MR. JORDAN said [having to pay] interest is an incentive for carriers to pay promptly, and it also provides an upfront recognition of the "time value" of money. He mentioned that HB 113 is not just for physicians, it is for all types of medical care providers that submit bills such as hospitals, nurse practitioners, physician assistants, and so forth.

Number 1829

MR. JORDAN pointed out that the interest goes to the insured person unless that person requests that the claims be directly paid to the care provider. This is the process that is commonly known in the insurance world as the "assignment of benefit." Mr. Jardell had mentioned that H.R. 287, the federal bill, looks at some of the same issues that HB 113 looks at in Alaska. The [federal bill] has a 30-day timeliness parameter for paper claims and 15 days for electronic claims.

MR. JORDAN concluded by saying that the ASMA views this as a good first step, and said the linch pin of this legislation is the definition of a clean claim. He explained that the definition utilized in the proposed bill is the definition that is used in Medicare. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, there are provisions dealing with the confidentiality of medical records. He said this fits because under HIPAA, the Health Care Finance Administration (HCFA) recently published extensive regulations dealing with confidentiality of medical records. He said critical to this process is the determination of the minimal amount of information which needs to be submitted to a health insurer, while still protecting the individual's confidentiality. He said it is a work in progress. It is the ASMA's feeling that the definition of a clean claim will be driven by what comes out of the HIPAA. He stated that it would probably be the "minimal elements" that need to be completed on the HCFA 1500 form.

Number 1977

REPRESENTATIVE ROKEBERG asked Mr. Jordan if he thought Alaska would be "out on the cutting edge" by demanding electronic payment; it would be considered an insurance mandate, and would deter insurance companies [from providing services] in Alaska. He said if this bill is adopted, Alaska would be the most aggressive state, and he asked what the consequences might be.

MR. JORDAN responded that there might be testimony that could address that because his comments would just be conjecture.

REPRESENTATIVE ROKEBERG indicated there is always a problem between groups covered by the Employee Retirement Income Security Act of 1971 (ERISA), and federal and state laws. He asked Mr. Jordan if this bill would only apply to those not in an ERISA-covered groups.

MR. JORDAN said he thought this would only apply to those entities that can be regulated by the state Division of Insurance; it wouldn't apply to the ERISA-covered groups.

Number 2083

REPRESENTATIVE ROKEBERG said this would cover the same types of people that an insurance mandate would, which is a small number. This would include 10 or 15 [percent] of people in the state, particularly if the Indian Health Service (IHS) provisions are

fully applied. He said if one has to force the systems to be compliant, it drags everyone along with it.

Number 2129

MIKE HAUGEN, Executive Director, Alaska Physicians and Surgeons, an independent practice association in Anchorage, said he represents roughly 165 doctors, primarily specialists. He said he wanted to speak about the costs associated with late payments to his doctors' offices. The diversity of the groups he represents ranges from an office with 20 doctors, down to single practitioners. He stated that cost has a time component with it, and if one of his smaller doctor's offices doesn't get paid, it is forced to hire additional staff to process claims. Those costs are ultimately transferred to the consumer in the form of higher medical costs.

MR. HAUGEN said the committee would hear testimony from one of the larger groups in town that has the luxury of hiring an excellent staff person who makes sure that the doctors get paid. He said many of his smaller doctor [groups] can't afford to do that, and are forced [to settle] for partial-claim payments. If an office doesn't have the expertise to follow a claim, it can be the end of the line. Insurance companies have argued that if they are forced to modernize their computer systems so claims can be processed sooner, it imposes a cost that will be passed on to the beneficiaries in the form of higher premiums. He thinks the consumers in Alaska are currently bearing that cost anyway because there are lots of extra staff people in his doctor's offices who do nothing but track claims. He said if the process can be streamlined, it would require fewer staff.

Number 2217

MR. HAUGEN remarked that there is an ongoing problem with Medicare and access for elderly [people] in this state. He said a lot of his physicians simply couldn't afford to see as many Medicare patients as they would like. If doctors could lower the cost of doing healthcare, they may feel more inclined to take on more Medicare patients. He said Medicare patients just don't "pay the freight" when it comes to running a medical office. Ultimately, if the [insurance] carrier can pay the doctor more promptly, everyone will be better off.

Number 2250

JEFF DAVIS, Executive Director, Blue Cross Blue Shield of Alaska, emphasized that his company believes in and supports prompt payment. He said there are 62,000 members in the Alaska group. "We" pay 86.7 percent of all claims within 14 calendar days, and 97 percent of all claims within 30 calendar days. Blue Cross Blue Shield believes that the 30-day payment standard for claims is reasonable and serves all parties. A concern "we" have with HB 113 is the provision for the 10-workday turnaround for electronic claims. He said the 20-[work]day [requirement] for paper claims is consistent with the 30-[calendar]-day standard.

MR. DAVIS remarked that the clock running working on the date of receipt of a paper claim. It takes them a short period of time to enter the claim into the system, he said, and at that point, the claim becomes indistinguishable in its process from an electronic claim. He said "we" can meet that standard, but there is concern about the cost to members, because it would take additional staff to meet the 10-day turnaround [time] for an electronic claim.

Number 2372

MR. DAVIS explained that the claims that go through without any question are not the issue; it is those claims for which a human being has to get involved and ask questions, and so forth. The second concern [Blue Cross Blue Shield] has about the bill is not that the interest would be attached to a late payment, but the methodology that will be used. Mr. Davis said that there was no widely accepted methodology for calculating interest for the claims that go beyond the established standard. If Alaska ends up with a standard that is different from other states, it could become a barrier to doing business in the state, especially for those carriers that have small market share, or those that would [like to] enter the state.

Number 2422

MR. DAVIS said [Blue Cross Blue Shield] would be happy to work with the legislature to modify the bill and make the interest calculations and standards acceptable from their point of view. With the changes, Blue Cross Blue Shield would support it.

Number 2436

REPRESENTATIVE KOTT verified with Mr. Davis that the bill would be more palatable if it reflected 30 calendar days for both electronic and paper claims.

MR. DAVIS responded affirmatively.

TAPE 01-23, SIDE B
Number 2457

REPRESENTATIVE HAYES remarked that it seems that electronic claims would be much faster [to process].

MR. DAVIS responded that "we" have people who specialize in Alaskan claims only. He said most of that group is located in Washington [state], with a portion in the Anchorage office. He said for most purposes, the method of transmission speeds up the process, but the time clock on this bill starts with receipt, so whether a claim is received in the mail today or electronically today, the clock starts today for both.

Number 2396

REPRESENTATIVE HAYES asked about Blue Cross Blue Shield's system of processing [claims].

Number 2376

MR. DAVIS explained that providers can submit an electronic [claim], and, if they do, it is received by the claims system and goes through an auto-adjudication process. A large percentage [of the claims] go through without ever being touched by a human being, and are paid quickly. When claims need to be "touched," this means that a person needs to look at them and understand what is being done.

MR. DAVIS explained that all claims become electronic claims once they have been entered [into the system], and the process is indistinguishable from that point forward.

Number 2319

REPRESENTATIVE HAYES said it seem that if there is an electronic entry, it should take less time than if it is done on paper and through the mail.

MR. DAVIS replied that the clock starts when his company receives the claim, so it is really [just] processing time.

REPRESENTATIVE HAYES asked Mr. Davis if he just wants a time frame that is either 30 days or 15 days, but for both types of claims to have the same time frame.

MR. DAVIS indicated affirmatively.

Number 2267

MR. DAVIS said there are some [up-and-coming] efficiencies that could be adopted to handle claims electronically. He explained that rather than manually entering claims, one could get optical-character recognition (OCR), which would cut off a day or so. If the standard was 20 working days for a paper claim, and 19 for an electronic claim, that would make sense, he said, because it would represent the efficiencies that occur after the claim is received - which is the time frame in question.

MR. DAVIS explained that the majority of claims, whether received electronically or not, still require a human to look at them. He said if the company didn't have information, for example, on whether a person had [other insurance] coverage, that would be a reason to ask a question [and pull the claim for further investigation].

MR. DAVIS added that his company now asks for that information up front, and it is entered into the system so claims can go right through.

Number 2118

REPRESENTATIVE ROKEBERG referred to page 2, subsection (d), which reads in part:

A claim for which a health care insurer provides appropriate notice of a deficiency ... [under] (b) of this section must be paid within five [working] days after receipt of those items listed as being deficient. If payment is not made within five working days, the claim is presumed to be a clean claim.

REPRESENTATIVE ROKEBERG asked if that [section] troubled Mr. Davis, and went on to ask if Mr. Davis' company pays partial claims.

MR. DAVIS gave an example. If a member has a bill for \$100, and the member's plan pays 80 percent of covered charges, then Blue

Cross Blue Shield would pay \$80. He said the interest [accrued] would be on the portion owed by the plan, rather than the total bill, including the portion owed by the member.

REPRESENTATIVE ROKEBERG, turning his attention to another issue, asked Mr. Davis if there is anything in this legislation that is inconsistent with the new "Patients' Bill of Rights" that takes effect July 1, 2001.

Number 2050

MR. DAVIS responded that he had a question about lines 23-24 on page 2. He said oftentimes there is a timely-payment provision in provider contracts, but interpreted it to mean that if the provision was more stringent in the provider contract, then it would have to be met, and if it was less stringent, then state law would have to be met.

Number 2026

REPRESENTATIVE CRAWFORD said Representative Green put the two separate time periods in the bill to give an incentive to doctors filing electronically. He understands, from what Mr. Davis has said, that he doesn't think there should be an incentive to get doctors to file electronically. He asked Mr. Davis whether there were savings in filing electronically.

Number 1978

MR. DAVIS remarked that the savings are the difference between having a claim go right into the system, and having a claim entered into the system by someone. [Blue Cross Blue Shield] supports electronic filing by Alaskan providers and has worked closely with physicians in Alaska for over ten years. The company has used member resources to help set that up. There are other reasons that [some] providers aren't interested, he explained, and oftentimes a small office just doesn't want to deal with it. He pointed out that many providers don't bill for their patients, but collect the money up front, and the member has to worry about submitting the claim [to the insurance company].

MR. DAVIS said the other concern he has about using it as an incentive is that [Blue Cross Blue Shield] is a taxable, not-for-profit organization; the cost of providing coverage is ultimately borne by the members, because there is no other money; if charging interest is to be an incentive for providers

to submit electronically, it is the members' money being used to induce a physician to set up electronically, which seems odd to him.

Number 1904

REPRESENTATIVE KOTT asked Mr. Davis if part of the incentive wouldn't just be the ease and understanding that the company already received it, and [the ability to] get instant feedback. He also asked if organizations could pay claims electronically.

Number 1852

MR. DAVIS responded that at this time, it is his understanding that there is not direct deposit. He said "we" receive a claim, it goes through the system and is adjudicated, and a check is physically cut and sent to the provider along with an explanation of benefits; an explanation of benefits also goes to the member showing what was paid.

Number 1832

REPRESENTATIVE KOTT asked for clarification from Mr. Davis about his previous response regarding the days for payment. He asked Mr. Davis to clarify that his [previous] affirmative response meant that he would accept a 15-day standard [for both types of claims].

MR. DAVIS said "we" support a standard that is either 30 calendar days or 20 working days, which are essentially the same thing.

REPRESENTATIVE KOTT asked Mr. Davis if there is provision in statute that says an insurance company has to render payment to the member within a certain period of time [if the payment is submitted by the member, not the provider].

MR. DAVIS said he understood it to be the same whether the payment goes to a member or to a provider.

Number 1740

REPRESENTATIVE ROKEBERG asked Mr. Davis what percentage Blue Cross Blue Shield holds of the market.

MR. DAVIS responded that [Blue Cross Blue Shield] represents 105,000 members, and he believed the total market to be

approximately 250,000 members. He clarified that Blue Cross Blue Shield has 53 percent of the insured market.

Number 1695

REPRESENTATIVE ROKEBERG said only a portion of this bill would be applicable to a percentage of that market because of the ERISA requirements. He said this bill is applicable to 15 to 20 percent, and if Blue Cross Blue Shield has half of the insured, the cost shift from the providers to the insurance companies is back to the people again, at less than 10 or 15 percent of the market. As a result, he thinks the standards of practice would change.

MR. DAVIS clarified that of the 250,000 [members], very few probably have an insured program; this bill would only apply to those. He said Blue Cross Blue Shield has 53 percent of this group. He agreed that, in most cases, if a carrier has a mix of insured and self-funded businesses, "they" would apply one set of standards, and it would be the most stringent set of standards as far as turnaround [time]. "They" probably wouldn't pay interest on the self-insurers, [since that wouldn't be] required, but as far as turnaround, the same [standard] would probably be applied to all.

REPRESENTATIVE ROKEBERG followed up by asking - if this was adopted - isn't it correct that 80 percent [of the carriers] would speed up the time [requirement], but wouldn't pay interest because of their exemption from enforcement as ERISA-type insurers.

MR. DAVIS speculated that this would be the business decision most carriers would make. Carriers would set up systems to meet the turnaround standards, but if they weren't required to pay interest, they would probably not choose to make interest payments.

REPRESENTATIVE ROKEBERG said the smaller groups would bear the burden, and this would be a disincentive for underwriting to (indisc.) in the state.

Number 1562

CHAIR MURKOWSKI asked about the interest methodology. She said in the bill, the interest would be calculated on each individual account. She asked if Mr. Davis had found information where the

methodology is different, where interest is calculated based on the provider.

Number 1534

MR. DAVIS stated that there is much variation among jurisdictions, and there doesn't appear to be one methodology that is widely accepted. He said it raises the concern that if Alaska adopts a different methodology, it potentially places a barrier to entering this market.

Number 1496

GUY BELL, Director, Division of Retirement and Benefits, Department of Administration, gave the following background information. He said the division administers health plans for 22,000 retired public employees, teachers, and their dependents; 11,000 active state employees and their dependents [are also covered]. He said "we" have a fully self-insured medical plan; Aetna, the claims administrator, is paid a per-member administrative fee, and the division covers the cost of claims.

MR. BELL remarked that the division is not sure whether it is subject to this legislation, but doesn't assume that it is, because the division is self-insured. However, in the past the division has tended to follow mandates set by the legislature, as a matter of public policy.

Number 1423

MR. BELL said generally, the division would be concerned about anything that would increase plan cost. The cost of interest, he said, if it were applied, would raise plan premiums. He also mentioned that the definition of a clean claim might need to be clarified.

MR. BELL said the division has incentives for prompt payment within its contract with the third-party administrator. The incentive is that 80 percent of all claims [must] be paid within 12 calendar days, and if this is not met, the third-party administrator is required to pay penalties. He clarified that the penalties are charged to the plan, not the members or providers.

Number 1358

CHAIR MURKOWSKI asked Mr. Bell if, from his perspective, there is a difference between electronic and paper claims.

MR. BELL said the division doesn't actually administer the claims; that would be a question for Aetna, as the third-party administrator.

REPRESENTATIVE ROKEBERG asked Mr. Bell if the division's policy has been driven by other legislation, mandates, or an executive decision.

MR. BELL indicated that it was an executive decision.

Number 1252

REPRESENTATIVE HAYES asked Mr. Bell to provide him with data on how quickly dental claims are paid, because dental claims seem to take a lot longer.

MR. BELL said he believed the division could provide data from Aetna's database on the turnaround times over the past months.

Number 1192

KATIE CAMPBELL, Life and Health Actuary, Division of Insurance, Department of Community and Economic Development (DCED), stated that the division is generally supportive of the bill and the 20-working-day requirement. She said she had spoken to Representative Green's office, and "we" had some technical suggestions for cleaning up some provisions in the bill. She clarified that currently, there isn't a reporting requirement; insurers don't have to report percentages of claims that are paid within a time period. This would be new to the statute and to the division, she explained.

REPRESENTATIVE ROKEBERG mentioned the potential HCFA regulations. He asked Ms. Campbell if she sees any problems with the definition of a clean claim, and asked whether there is any interrelationship between the upcoming regulations and the bill.

Number 1095

MS. CAMPBELL responded that she is not too familiar with the definition of a clean claim. She knew that some work was being done on the actual standard claim form. Other states actually avoid the clean claim definition, she remarked, and [just] have

companies provide standard information; the HCFA reporting claim form is one [way of providing that information]. If the information is provided on that [form], then the claim has to be processed within the time frame.

Number 1051

NICOLE BAGBY, Account Executive, Aetna US Healthcare, Seattle Office, via teleconference, said Aetna currently holds a large percentage of the self-insured health insurance market in Alaska. There are only about 10,000 members in the fully insured market. She testified in opposition to HB 113, as it is currently drafted, and remarked that Aetna has many concerns with the legislation.

MS. BAGBY said the bill is not consistent with the claim-payment deadline required by Medicare. Medicare uses a 30 calendar-day deadline for paper claims, and a 15-day [deadline] for electronic claims. She remarked that the 30-day-payment schedule is pretty common to all businesses, not just health insurance companies.

MS. BAGBY said Aetna also believes that the definition of a clean claim needs to be expanded. There will be disputes about the definition if the bill passes, and the Division of Insurance or the courts will have to adjudicate them.

MS. BAGBY pointed out that the bill might [actually] slow down processing claims. Instead of accepting a claim, and trying to fix some of the issues, insurers may reject the claim up front, because of the potential for interest penalties.

MS. BAGBY stated that Aetna also believes that the penalty for a claim payment, mistakenly made to a patient instead of a physician, is too severe. This bill would require Aetna to pay the claim twice, once to the patient and once to the physician.

MS. BAGBY stated that the bill would require Aetna to set up new tracking and reporting systems for the reports that would need to be submitted quarterly to the state. It is another added expense to the healthcare administrative system in Alaska, she commented.

MS. BAGBY relayed that most of Aetna's self-insured businesses have contractual or performance guarantees with customers that payments would be made in a relatively short period of time. Aetna puts its money at risk to meet these requirements, and

doesn't profit from slow payments; the pool of money that is used to pay the claims belongs to the self-insured customers, not to Aetna.

MS. BAGBY concluded by saying that the company still needs some additional time to provide specific language recommendations to the committee.

Number 0834

REPRESENTATIVE ROKEBERG asked whether Aetna currently has to supply reports, because it was mentioned during Ms. Bagby's testimony that the company would have to set up a whole new system of tracking. He also asked her to point out in the bill where it refers to payments needing to be made to both the claimant and the provider.

KATHY ODEGARD, Operations Manager, Aetna US Healthcare, responded that Aetna does customer-specific reports, not [reports with] statewide data.

MS. BAGBY referred to page 2, line 26-28, subsection (e) [which outlines this language].

Number 0751

CHAIR MURKOWSKI remarked that she understood it to mean that if there had been a change in whom the payment went to, as is currently in statute, the insurer would have the right to recovery [of costs] against the individual or provider that had erroneously received the payment.

Number 0674

JAMES E. BROOKS, Executive Director, Providence Anchorage Anesthesia Medical Group, a group of 19 anesthesiologists, said he had information from a provider's perspective about claim adjudication in the state.

MR. BROOKS pointed out that his data would differ considerably from that provided by the insurance representatives, but said he is prepared to back up his data. He said Mike Haugen asked him to profile, from his practice's perspective, claims of adjudication. [Mr. Brooks had a several-page handout for the committee.] He explained that he had used the payments that came in during the month of December, and had profiled three

different payers. The sample size [of insured customers] was 241 for one payer, 211 for another, and 37 for the third.

MR. BROOKS proposed that in terms of achieving prompt claims adjudication, the performance of the insurers, providers, and the public are not aligned.

Number 0596

MR. BROOKS remarked that the people of Alaska pay premiums, and expect not only to have the insurance costs covered, but also for [the process] to be prompt and efficient. He said his data shows that those payments are not prompt and efficient, and suggested that only legislation that changes economic incentives, so it becomes the most profitable form of business, will change claim adjudication behavior.

MR. BROOKS said as a provider, he hires a coding expert to make sure that his codes are correct, and four claims specialists to track claims over the entire process. "We" audit and track claims until closure. "Our" average time from the date of service to the time a claim leaves the office is three working days. He explained that in his analysis, he gave the insurers the benefit of seven days from the time of service, so that wouldn't interfere with the "metric"; he added that he didn't use a 30-day metric.

Number 0455

MR. BROOKS said for efficiency and promptness of payment he used a 60-day metric. The impact on his organization from not being paid promptly is a minimum of one full-time employee (FTE), plus some additional mail and processing costs when claims have to be processed multiple times.

MR. BROOKS referred to the challenges faced by customers. When a claim has to be processed multiple times, his company ends up paying for that cost while the insurer has the money that is due to the patient and to "us". He explained the process of a claim appeal and gave the committee copies of some claims that had recently been sent in on appeal. Referring to one particular claim on the handout, Mr. Brooks said he delivered the service on April 6, and was paid incorrectly. He said he then began the process of trying to get paid correctly. During this process he spoke to five different representatives between October 13 and December 6, trying to straighten the claim out.

MR. BROOKS said he finally resorted to a formal appeal. He attached the HCFA 1500 [form] that was sent originally; the explanation of benefit from the provider; the follow-up explanation of benefit; the coding references so [the insurer] could see how it is suppose to be paid; a record of care so there would be no doubt about what services was rendered; and an extract of his contract that tells [the insurer] what he was supposed to be paid for services. He said he does this for two reasons. First, it gives [the insurer] the best possibility of finally paying him correctly for a service that was rendered in April, and second, in the event he doesn't get paid after the appeals process, he is ready to turn it over to a lawyer to pursue payment.

MR. BROOKS remarked that this is just an example of the frustration a provider's office goes through to get paid when claims aren't processed correctly the first time. He said his company has staff turnover because one gets tired, being caught in the middle.

Number 0285

MR. BROOKS pointed out that he has had insurers admit to him that as late as July of 2000, they had not integrated [into their system] the new coding changes, which are published by the American Medical Association (AMA) for processing claims. Consequently, all of the claims that hit their system and that have a requirement for the coding updates to be current will be rejected and denied.

MR. BROOKS remarked that he has also had people admit to him that the computer system that considers the claims a second time, those that are processed for federal employees, will not recognize the coding modifiers. This means those claims are denied and rejected. He said another insurer admitted to him that when [the company] is overwhelmed with work in Seattle, it outsources the work to California. He stated that when this happens, there is a quality problem. [He passed out some information on a claim that had been outsourced.]

MR. BROOKS he gave an example of a claim for delivering 25 units of anesthesia services; he said he was paid for only one unit: the company owed him \$1,660, and only paid him \$92. If this only happened once, he said, it wouldn't be a major consideration. He stated that of the three pages he gave the committee, one would find that this happens over and over again. He said he doesn't have a managed-care contract with this

insurer, so there is no negotiated adjustment. The company chose to pay \$327 when it owed \$664, based on a negotiated adjustment.

Number 0045

MR. BROOKS said this company would frequently tell the public that he only filed a claim for one unit of service. He met with representatives of this company, trying to rectify this, and finally resorted to sending every patient a copy of his or her claim form when it was filed. This costs him another claim form and postage, but he has made that patient his advocate for being paid promptly and accurately. When that insurer tells a patient that he filed the claim incorrectly, the patient is already informed. He said he believes this is why the company is coming to see him to [try to] rectify the situation.

MR. BROOKS said most recently, another company hired a subcontractor to do the data entry to transform the HCFA 1500 from a paper copy to an electronic file. The subcontractor was leaving elements of information off, although the company didn't tell the public that. The company [instead] chose to tell the public that he hadn't put those elements of information on the claim, which then backfired on [the company].

TAPE 01-24, SIDE A

Number 0036

MR. BROOKS referred to one of the handouts and a company he had profiled. He said the company paid him accurately 89 percent of the time, and in a timely manner, in 60 days or less. [The other two companies he profiled] operated at the 74 to 76 percent level of performance for paying accurately, in 60 days or less. He equated this to a company that processes 1,000 claims a month, and said 250 would be erroneous and late at a time. Meanwhile, through time, inaccurately paid claims are accumulating, month after month.

MR. BROOKS directed the committee's attention to the handout. He said he picked the month of December and showed the payments received. He explained that this was when the money actually arrived at his organization. He said to make the data fair, when he profiled these insurers, he took out every instance in which [the insurer] was a secondary payer because he didn't want the performance metrics used to be flawed because someone else delayed the payment of a claim. He also removed the instances

in which a claim was denied for something that his company might have made an error on. To back up his data, he offered Excel spreadsheets [for the committee to review].

MR. BROOKS said anesthesia is a very simple business, in his opinion, for which to file claims and get paid. There is a base unit for a particular service, and there are units of time-of-service that are rendered. Those two are put together and go on a claim form. He said his organization uses the industry standard, the HCFA 1500 claim form, for all of the private payers. He said the computer system wouldn't allow him to leave elements of information off.

MR. BROOKS remarked that it would take the committee's assistance and support to change the behavior of insurers; he suggested that this costs the state's providers a tremendous amount of money. He stated that he has separate claims people, and a separate accounting section that tracks every payment that is not accurate until the day it is resolved. When he finally turns it over to legal counsel, counsel gets paid 35 percent of whatever is collected; [additionally, he pays] all of the costs to get to that point. Mr. Brooks said he does it because if he doesn't, he believes that there are some insurers that wouldn't pay him accurately; ultimately, it ends up hurting the patients, because they pay the premiums.

MR. BROOKS said his organization takes care of every person who comes in, whether he or she is on Medicare or Medicaid, but "we" have to get paid to stay in business.

Number 0375

REPRESENTATIVE KOTT asked if Mr. Brooks is seeking a remedy in the form of an amendment to this legislation that deals with accurate payments. He said he doesn't believe this legislation deals with accuracy of payments.

MR. BROOKS replied that he supports the bill because he thinks it is a step in the right direction. It is not perfect legislation, however, because there are companies that have data to show that they paid all of their claims within a certain amount of time, but it doesn't reflect whether they paid them correctly. He said in time, "we" can deal with the issue of being paid accurately.

Number 0441

REPRESENTATIVE KOTT asked Mr. Brooks if he could seek a remedy at the state level within the Division of Insurance to investigate those companies who are repeatedly paying claims inaccurately.

MR. BROOKS said his organization has helped the public appeal to the division for help, but has not found it to be an effective way of dealing with the insurers.

REPRESENTATIVE ROKEBERG asked what accounts for most of the inaccuracy of claim payments.

MR. BROOKS said it takes him two years to train a person to function efficiently as a claims specialist because the government has many regulations and processing a claim is complex.

MR. BROOKS said if the new codes, published each year by the AMA, are not implemented into the computer system until July, claims will be processed incorrectly for seven months, even if the information is entered correctly.

MR. BROOKS pointed out that this information is published in October so people will take the correct actions to update software, train staff, and be ready to go on January 1st. He said the only thing he can say is that it is not important enough to them to make the capital investment.

Number 0758

REPRESENTATIVE ROKEBERG asked Mr. Brooks if he thought the situation existed to intentionally create a bigger "cash float."

MR. BROOKS said there are probably some companies out there that are doing business that way; however, what he has seen, by a company's own admission, has been that staff training and education is not up to standard.

MR. BROOKS suggested that his partners on the insurance side have an obligation to the people paying the premiums to make the capital investment to train and educate employees. If they fail to do that, they elevate costs; a small practice in this state doesn't have the ability to track claims down and will lose the money. He said the little mom-and-dad practices out there don't have "a prayer" of getting paid effectively in this environment.

MR. BROOKS referred to insurer C on his handout. He said in looking at the spreadsheet, one would find that this company paid him most of the time in less than 60 days. In fact, it paid him most of the time in less than 30 days, unlike the other two insurers he profiled.

Number 0929

REPRESENTATIVE ROKEBERG said it is a shame that the legislature can't legislate against sloppy business practices, bad management, and human resource problems that this state and others are having. He asked Mr. Brooks if he thought demanding earlier payment would be the panacea for the problems, and force companies to make the capital investment.

MR. BROOKS responded that it is a step in the right direction. He went on to say that when the insurer has to report back to Wall Street on why it is paying penalties for doing sloppy business, there might be a change.

Number 1023

REPRESENTATIVE KOTT said he is supportive of using 30 days for [payment] of both paper and electronic claims. He said he went through the Alaska State Medical Association chart, and the average [time frame is] 36 days. And he thinks 30 [days] is under that. He said according to the testimony from the last person, there was at least one insurer who is paying promptly and efficiently under 30 days.

REPRESENTATIVE KOTT referred to the schematics in the sponsor's packet, and said of the 39 states, 30 have 30 or 45 days, 28 have the same [claim filing requirements], and there is justification to keep them the same. He stated that he thought 30 days was appropriate. [HB 113 was held over]

ADJOURNMENT

There being no further business before the committee, the House Labor and Commerce Standing Committee meeting was adjourned at 5:10 p.m.

