MEDICAL PLAZA INTERNAL MEDICINE

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TO: House Insurance Committee
FROM: Kathy Vance
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SUBJECT: HB 2565 Concerning health care expense transparency
A Primary Care Perspective

Thank you, Chairman Shultz and committee members, for the opportunity to submit the following in support of House Bill 2565.

My name is Kathy Vance. I have managed a primary care practice in the Kansas City area for 27 years. I have a Masters in Business and a Masters in Health Services Administration from the University of Kansas. Medical Plaza Internal Medicine is currently affiliated with the University of Kansas Medical Center and we are located in Overland Park, Kansas.

We are supporting House Bill 2565 because physician offices need the ability to check coverage for medical services in order to allow patients the opportunity to make informed health care decisions. Patients need to understand how insurance carriers are going to process their claims so they can decide what care they wish to purchase. Patients should be allowed to select services with the advice of their physician and be allowed to plan their health care.

Allowable amounts available on the internet tell the patient what the insurance carrier will pay IF they agree to cover the services, but the websites do not inform the patient how the claim will be processed or whether the insurance carrier is going to "allow" the charges. There are many reasons why an insurance carrier may process a claim and not cover certain services.

I will explain a few of the most common reasons insurance carriers may not cover services recommended by a provider and why it is important for patients to have this basic information before they become responsible for payment.

Non-Covered Services: These are services that an insurance carrier considers non-payable because of insurance carrier policy such as adult immunizations, frequency of testing, limitations because of age or gender, investigational testing, etc. Non-covered services vary widely by insurance carrier and by employer contract within the same insurance carrier. The fact that a patient has a certain type of insurance does not provide any indication whether that patient's particular contract will cover a service.

Having a website with allowables will not help the patient know whether their insurance carrier is going to pay for a service at all. If providers could test coverage on behalf of a patient, then

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the patient could decide which services they wish to purchase. Sometimes a service may be covered with one diagnosis, but not another, and both diagnoses are appropriate for submitting the claim. If the provider could submit the claim on behalf of the patient, we might be able to provide coverage for the patient.

Preventive Care: While the national trend and regulation is to provide patients with preventive care services, there is wide variability in what insurance carriers consider to be covered under preventive care. There is one national carrier that will not cover services that a patient might consider to be preventive care. They do not cover general health panels in laboratory services, urinalysis, chest x-rays, electrocardiograms, etc. Other carriers might pay for all of these services under their preventive care policies. Employer contracts may also have limitations on what is considered a covered service.

Having a website with allowables will not help the patient know whether their insurance carrier is going to cover screening tests. The allowable will be on the website, but the carrier may not pay for the service.

Patients could discuss non-covered tests with their providers before the testing is done, and decide whether they want to pursue the test.

Screening Tests: Screening tests would involve testing that could be advised by a physician to rule out certain illnesses. Again, insurance company policies vary widely on what screening tests they will provide to their subscribers. These policies vary by employer contract, by frequency, etc. Though a physician may feel it important to screen a patient for a disease, if the patient is fortunate enough not to have the disease, he may not have coverage for the testing.

Allowables, again, do not answer these questions.

Bundling Rules: Bundling is a process in which the insurance carrier will have software rules that will "bundle" codes indicating that, in their opinion, a code is included in the reimbursement of another code. An example would be, in primary care, insurance might "bundle" a blood draw with an office call indicating that payment for the office call includes a blood draw. There are no uniform rules on how insurance carriers will "bundle" codes. Carriers may pay for a service in one claim and deny it in another.

Allowables will be on the website, but they tell the patient nothing about how they are going to process the claim.

Place of Service: There are insurance companies that will cover some immunizations in a pharmacy, but will not cover the immunization in a physician's office. Shingles vaccine is an example, a $200 immunization. Sometimes it is allowed in the physician office, and sometimes only in a pharmacy.

Allowables will not tell the patient where they need to go to purchase the service.

Patients advise us they would like to use their preventive, or wellness, benefit from their insurance contract. Some policies waive deductibles and copays on preventive services, and as a result, patients wish to utilize their full benefits. These patients may have a diagnosis that would also cover their services. We need to be able to transmit an electronic claim using their preventive benefit, and if it is not covered, be allowed to use their diagnostic benefits instead.

It becomes very important that the claim be handled as if it were going to be processed for payment by the carrier. This, then, tells the patient if they will be charged deductible, copays, and whether some of

the services will be their total responsibility. It is only then that a patient can truly make an informed decision on what services they wish to purchase, and what services they do NOT wish to purchase.

We make these calls to the carriers today, on behalf of the patient, to provide them advanced notice of their responsibility for charges. The telephone queues at insurance companies are routinely 15-20 minutes or more. Physician office staff may wait in a queue for 20 minutes, only to be transferred to another queue because the patient's employer contract is serviced by another unit, and the 20 minute wait begins again. Because of the time constraints, we make these calls only on the most costly services.

If we try to make telephone calls to call centers, the patient's appointment is over before we are able to get the information they need to make informed decisions. Physician appointments typically run in fifteen minute increments. Call centers have waiting queues that average 15-20 minutes, and then it might take another 10 minutes to receive an answer.

In addition, insurance call centers inform us up front that they will not guarantee their answers. If we call a carrier and the insurance employee indicates a patient has coverage, but upon processing of the claim, the carrier denies coverage, who is responsible?

Real-time, accurate information will solve this problem.

Primary care may have lower costs to the patient, but we have a higher volume of tests to which patients are exposed. The patient may make an extra effort to find out what their costs will be for knee surgery, but find out they owe for services they thought would be covered at their primary care office.

Real-time pre-determination of claims will provide protection to the patient and allow them to make good, informed decisions about their health care.

I urge your support of HB 2565 to protect a patient's right to pre-determination of their costs when accessing health care services.

NOTE: The views contained in this testimony are the views of Kathy Vance and may or may not reflect the views of the University of Kansas Medical Center.

We feel it is extremely important for us to have the payment information at hand to give the patient financial options along with healthcare options that work for them. It might be that chronic patients who are compliant with their medications and agree to have periodic lab tests could reduce their actual office visits by one or two a year with some oversight from the PCMH team. Our physicians and staff have to be receptive to each patient's situation along with the challenges they face. House Bill 2565 would assist us in doing that.

Patient Responsibility/Bad Debt

Usually, it is 20-30 days from the day of service that an insurance payment is received and a patient balance is billed. It is not unusual for another 30-60 days before we see a payment from the patient. There are patients that never pay their bill. Some patients have no office visit benefit, but we still are required to send the claim to the carrier before we charge the patient. Our bad debt ratio for one carrier, who offers high deductible health plans, lower premiums, and fewer benefits, has grown from 1.5% in 2005 to 7% in 2010 for that patient base. I believe the passage of HB 2565 and the implementation of the HCPD will help us reduce our bad debt and help us maintain financial integrity.

Our group is eager for House Bill 2565. It finally gives the physicians and patients the opportunity to make informed financial decisions about the healthcare services, tests, and treatments that are available to them. The consideration of a bill like HB2565 is long overdue.