

**TESTIMONY PENNSYLVANIA SENATE FINANCE AND INSURANCE COMMITTEE**

**12/16/2009**

**8:30AM**

**GOOD MORNING CHAIRMAN WHITE AND DISTINGUISHED MEMBERS OF THE SENATE FINANCE AND BANKING COMMITTEE. I AM DWIGHT MICHAEL. I AM HERE TO SHARE MY REFORMED AND INFORMED BELIEF THAT SENATE BILL 400 IS BY FAR THE BEST WAY TO PROVIDE HIGH-QUALITY, AFFORDABLE, ACCESSIBLE HEALTHCARE TO ALL PENNSYLVANIANS AT A COST TO PRACTICALLY ALL OF US THAT IS LESS THAN WHAT WE CURRENTLY PAY FOR OUR HEALTHCARE.**

**I WAS BORN AND RAISED IN HANOVER, PA.**

**I GRADUATED FROM GETTYSBURG COLLEGE, THE UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE, AND ST.MARGARET MEMORIAL HOSPITAL'S FAMILY PRACTICE RESIDENCY PROGRAM IN PITTSBURGH, PA.**

**I AM A FAMILY PHYSICIAN IN MY 25<sup>TH</sup> YEAR OF PRACTICE IN GETTYSBURG, PA. I AM THE OLDEST MEMBER OF A 5 PHYSICIAN FAMILY PRACTICE GROUP. I AM A REPUBLICAN AND HAVE BEEN FAIRLY CONSERVATIVE IN MY VIEWS OVER THE YEARS. MY WIFE, A SCHOOLBOARD MEMBER, AND I HAVE BEEN ACTIVE MEMBERS OF OUR COMMUNITY. WE HAVE RAISED 4 HEALTHY CHILDREN IN GETTYSBURG, PA.**

**I HAVE BEEN ASKED TO FOCUS MY COMMENTS ON WHY SB BILL 400 IS BENEFICIAL TO PHYSICIANS.**

**FIRST, THIS BILL WILL ALLOW US TO FOCUS MUCH MORE OF OUR TIME ON THE ACTUAL CARE OF THE PATIENT. WITH OUR PRESENT MULTIPAYER SYSTEM, WE SPEND AN INCREASING AND INORDINATE AMOUNT OF TIME DEALING WITH PRE-AUTHORIZATION OF CARE ORDERED, INCLUDING: MEDICATIONS , TREATMENTS, TESTING SUCH AS CAT SCANS, MRIs, and OTHER DIAGNOSTIC**

**PROCEDURES. DENIALS BY INSURANCE COMPANIES ARE ALL TOO FREQUENT. OUR NEED TO GAIN COVERAGE FOR THE RECOMMENDED CARE IS OFTEN MUCH MORE TIME-CONSUMING AND COSTLY THAN IT WAS IN THE PAST. A STUDY FROM THE JOURNAL OF PUBLIC AFFAIRS, MAY 2009, CONCLUDES THAT EACH PHYSICIAN IN AMERICA SPENDS \$68,000/YEAR JUST TO INTERACT WITH THE PRIVATE HEALTH INSURANCE INDUSTRY. OUR PRACTICE PARTICIPATES WITH 20 DIFFERENT INSURANCE COMPANIES, ALL OF WHICH HAVE THEIR OWN SET OF RULES AND HOOPS TO JUMP THROUGH. I HAVE BECOME CONVINCED THAT THEIR "RULES" HAVE MUCH MORE TO DO WITH THEIR PROFIT MARGIN THAN THEY DO WITH GOOD PATIENT CARE. I AM VERY SUSPICIOUS AT THIS POINT THAT SOME COMPANIES HAVE TAKEN THE TACT OF DENYING PAYMENT OF CLAIMS ON THE FIRST ATTEMPT NO MATTER THE APPROPRIATENESS OF THE CARE SUGGESTED.**

**THE FAMILY AND BUSINESS HEALTH SECURITY ACT, SB 400, WILL HAVE ONE SET OF RULES BY WHICH TO PRACTICE, BASED ON CLINICAL EFFECTIVENESS RESEARCH, CLINICAL OUTCOMES STUDIES THAT PROVE THE BENEFIT OF THE CARE WE PROVIDE, BOTH TESTING AND TREATMENTS. THIS BILL WILL MARKEDLY SIMPLIFY THE CURRENT ENVIRONMENT IN WHICH WE WORK. IT TRULY WILL GIVE US MORE TIME TO SEE PATIENTS.**

**SECOND, SB 400 WILL PROVIDE IMPROVED ABILITY TO TRACK AND TREND PHYSICIANS' CARE WITH ITS EMPHASIS ON THE USE OF INFORMATION TECHNOLOGY. IF THERE ARE PROVIDERS WHO ARE OUTLIERS TO THE SYSTEM IN THEIR STYLE OF CARE WHICH COMPROMISES THE HEALTH OF THEIR PATIENTS, THE PHYSICIANS WILL RECEIVE CONSTRUCTIVE CRITICISM WITH EXPECTATION OF IMPROVED CARE TO THEIR PATIENTS.**

**THIRD, SB 400 WILL STRENGTHEN THE PATIENT/PHYSICIAN RELATIONSHIP. HOW? PATIENTS WILL BE ABLE TO CHOOSE THEIR PROVIDERS OF CARE. THE PRESENT PRIVATE HEALTH INSURANCE DOMINATED SYSTEM CAUSES PATIENTS**

**TO LEAVE MY PRACTICE BECAUSE THEIR EMPLOYER CAN NO LONGER AFFORD THE PLAN THEY HAVE. IF THEIR PLAN CHANGES TO ONE THAT WE DO NOT PARTICIPATE IN, THEN THE PATIENT IS PRACTICALLY FORCED TO LEAVE OUR PRACTICE FOR A PHYSICIAN'S PRACTICE THAT PARTICIPATES IN THEIR PLAN. THIS HAPPENS EVERY YEAR IN OUR PRACTICE.**

**SB 400 ACTUALLY GIVES THE PATIENT THE RIGHT TO CHOOSE AND STAY WITH THEIR PROVIDERS. THE INSURANCE COMPANY NO LONGER CONTROLS THIS CHOICE. I WENT INTO FAMILY PRACTICE SO THAT I COULD TAKE CARE OF PATIENTS AND THEIR FAMILIES OVER THE COURSE OF MANY YEARS. I BELIEVE THAT I CAN PROVIDE BETTER CARE TO PATIENTS BECAUSE I KNOW AND UNDERSTAND THE PATIENT AND THE PEOPLE AROUND THE PATIENT OVER TIME. THIS HAS PLAYED OUT IN SOME OF MY FAMILIES, BUT OUR PRESENT "LACK" OF A COORDINATED HEALTHCARE SYSTEM NECESSITATES EMPLOYERS' FREQUENT DECISION TO CHANGE HEALTH INSURANCE PLANS TO SAVE MONEY. THIS TREND HAS GREATLY COMPROMISED THE CONTINUITY OF CARE THAT I BELIEVE IS SO IMPORTANT TO QUALITY OF CARE.**

**FOURTH, I BELIEVE THAT SB 400 WILL PROVIDE "FAIR REIMBURSEMENT" FOR PROVIDERS' SERVICES. FEES FOR INDEPENDENT PROVIDERS AND GLOBAL PAYMENTS FOR HOSPITALS AND OTHER INSTITUTIONS WILL BE NEGOTIATED ANNUALLY BASED ON THE PREVIOUS YEAR'S EXPENDITURES.**

**I BELIEVE THAT SB 400 WILL, OUT OF NECESSITY, STRENGTHEN PRIMARY CARE.**

**WE, AS A NATION, ARE PRESENTLY SPENDING AT LEAST \$400 BILLION DOLLARS A YEAR IN EXCESSIVE ADMINISTRATIVE COSTS DUE TO THE PRIVATE HEALTH INSURANCE INDUSTRY.**

**I BELIEVE THAT IF WE ELIMINATE THE EXCESSIVE ADMINISTRATIVE COSTS OF THE PRIVATE HEALTH INSURANCE INDUSTRY, WE CAN SAVE HUGE SUMS OF MONEY THAT CAN GO TOWARDS PROVIDING BETTER CARE TO ALL**

**PENNSYLVANIANS AND CAN FAIRLY REMBURSE PROVIDERS FOR THE CARE THAT THEY PROVIDE. ENACTED SB 400 WILL BE A WIN-WIN FOR THE CITIZENS OF PENNSYLVANIA, PATIENTS AND PROVIDERS ALIKE. BY THE WAY, DON'T FORGET THE 2+ BILLION DOLLARS PER YEAR IN SAVINGS WHEN CONSIDERING THE REDUCTION IN HEALTHCARE PREMIUMS OF ALL LEVELS OF GOVERNMENT IN PENNSYLVANIA.**

**FIFTH, I BELIEVE THAT EVEN THOUGH THE EXCELLENT MEDICAL LIABILITY PIECE OF LAST YEAR'S BILL HAS BEEN REMOVED, SB 400 WILL PROVIDE AN IMPROVED MEDICAL LIABILITY ENVIRONMENT IN PENNSYLVANIA FOR ALL PROVIDERS. PRESENTLY, PART OF THE AWARD IN A MEDICAL LIABILITY CASE INCLUDES "MEDICAL EXPENSES". UNDER THE TERMS OF SB 400, MEDICAL EXPENSES WILL ALREADY BE COVERED AND THEREFORE WILL NOT BE INCLUDED IN DETERMINATION OF THE AWARD GRANTED TO THE PLAINTIFF IN A MEDICAL LITIGATION CASE. THIS IMPROVED MEDICAL LIABILITY ENVIRONMENT WILL MAKE PENNSYLVANIA A MUCH MORE ATTRACTIVE STATE FOR PHYSICIANS TO PRACTICE. I REPEAT, PHYSICIANS WILL WANT TO WORK IN PENNSYLVANIA.**

**I HAVE FOLLOWED DEVELOPMENTS IN WASHINGTON VERY CAREFULLY THIS YEAR. AT THIS MOMENT, I BELIEVE THAT THEIR "SOLUTION" WILL FALL WOEFULLY SHORT OF THE MARK OF PROVIDING AFFORDABLE, ACCESSIBLE, HIGH-QUALITY HEALTHCARE FOR ALL. OUR STATE GOVERNMENT HAS RECEIVED A FEW BLACK EYES RECENTLY. WHEN YOU LEAD THE WAY, PASS SB 400, AND THIS BILL IS ENACTED, YOU WILL BE HONORED BY PENNSYLVANIANS, YOUNG, OLD, AS WELL AS FUTURE GENERATIONS. YOU WILL BE THE SAVIORS OF OUR STATE'S HEALTHCARE SYSTEM. FUTURE GENERATIONS OF AMERICANS WILL CREDIT YOU AS THE FATHERS OF OUR NATION'S EXEMPLARY, CIVILIZED HEALTHCARE SYSTEM IN WHICH EVERY PERSON RECEIVES HEALTHCARE. PENNSYLVANIA WILL BE THE STATE THAT BLAZES THE TRAIL OUR NATION FINALLY TAKES TO PROVIDE CIVILIZED HEALTHCARE FOR ALL.**



# In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

## Peering into the Black Box: Billing and Insurance Activities in a Medical Group

May 14, 2009

**Authors:** Julie Ann Sakowski, Ph.D., James G. Kahn, M.D., M.P.H., Richard G. Kronick, Ph.D., Jeffrey M. Newman, M.D., M.P.H., and Harold S. Luft, Ph.D.

**Journal:** *Health Affairs* Web Exclusive, May 14, 2009, w544–w554

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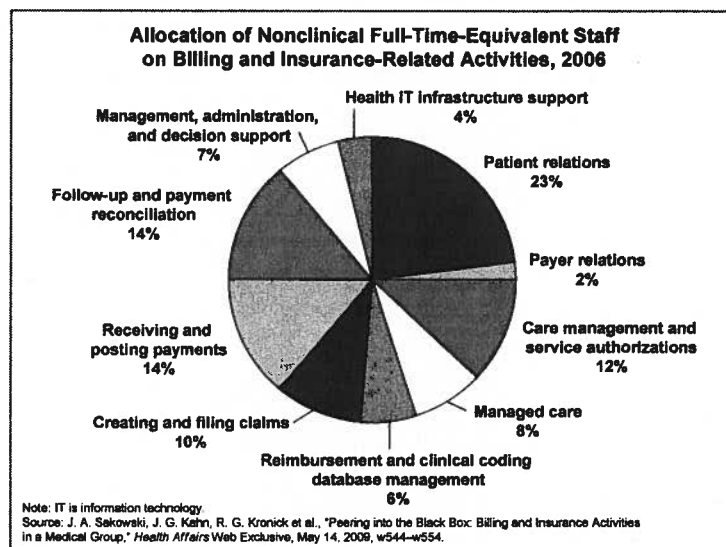
**Full text is available at:** <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.4.w544>

### Synopsis

A close analysis of the costs of billing and insurance tasks in a large medical group practice found that such tasks consume \$85,276 per full-time equivalent physician—or 10 percent of operating revenue. Standardizing health plan benefits and billing procedures would reduce administrative complexity and costs.

### The Issue

Health care organizations spend significant resources on the billing and insurance tasks required to secure payment for clinical services. Greater understanding of the time spent on various tasks could inform policy changes intended to simplify health care financing and reduce administrative costs.



### Key Findings

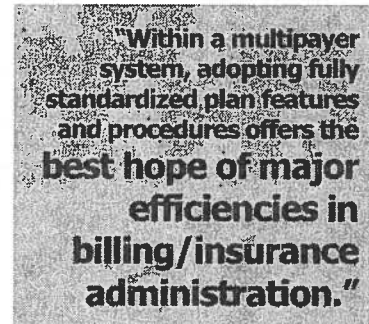
- At one large multispecialty medical group, a total of 0.67 nonclinical full-time equivalent (FTE) staff worked on billing and insurance activities for each FTE physician.
- Thirty-eight percent of nonclinical personnel working on billing and insurance activities, or 0.25 FTE per FTE physician, were performing tasks related to collecting payment: creating and filing claims, processing payments, and claim follow-up and payment reconciliation.

- Physicians reported spending an average of 35 minutes per day on billing and insurance activities; other clinical staff spent 38 minutes per day on such activities.
- In 2006, the cost of billing and insurance amounted to \$85,276 per FTE physician—10 percent of operating revenue.

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### **Addressing the Problem**

The current multipayer financing system makes billing and insurance tasks complicated and costly. Automation of certain tasks appears to have the potential to increase efficiency by reducing claim denials, ensuring coding compliance, and shortening the time to collect accounts receivable. Policies that call for strict standardization of health plan features and billing procedures have the potential to achieve efficiencies and reduce the costs related to billing and insurance.



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### **About the Study**

The authors quantified the costs related to the billing and insurance activities undertaken at a multispecialty medical group in order to receive payments for clinical services. Previous work has provided national estimates of the time spent on such activities; this study provided detail on the resources required to perform specific administrative tasks. Focusing on a large medical group in California, with more than 500 physicians practicing in multiple locations, the study was based on interviews, observation of workflow, analysis of department budgets, and an online survey of clinicians. The authors calculated the total costs of billing and insurance activities, taking into account salaries and benefits of staff, supplies, purchased services, and equipment.

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### **The Bottom Line**

Standardizing benefit plans and billing procedures has the potential to greatly reduce the complexity and thus the costs of billing and insurance tasks for medical groups.

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### **Citation**

J. A. Sakowski, J. G. Kahn, R. G. Kronick et al., "Peering into the Black Box: Billing and Insurance Activities in a Medical Group," *Health Affairs* Web Exclusive, May 14, 2009, w544–w554.

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*This summary was prepared by Martha Hostetter.*

## Physician Practices Spend \$31 Billion a Year on Health Insurance Plan Interaction

The average physician spends nearly three weeks a year interacting with health insurance plans, at an estimated annual cost to practices of \$31 billion, or \$68,274 on average per physician per year, according to a study published as a [Health Affairs Web Exclusive](#).


Researchers Lawrence P. Casalino, M.D., Ph.D., of Weill Cornell Medical College and colleagues surveyed nearly 900 physicians and medical group administrators to ascertain how much time physician practices spent interacting with health plans on prior-authorization requirements, pharmaceutical formularies, claims, credentialing, contracting, and quality data. Physicians reported spending nearly three weeks per year interacting with plans, while nursing staff spent more than 23 weeks per physician per year, and clerical staff spent 44 weeks per physician per year interacting with health plans. When converted to dollar estimates, the time accounts for as much as \$31 billion a year, or 6.9 percent of all U.S. expenditures for physician and clinical services.


A separate study published as a [Health Affairs Web Exclusive](#) found billing and insurance tasks in a large medical group practice consume \$85,276 per full-time equivalent physician—or 10 percent of operating revenue. The study, conducted by a team led by Julie Sakowski, Ph.D., of the Sutter Health Institute for Research and Education, found that clinicians spent more than 35 minutes per day performing these tasks and that these activities required the equivalent of 0.67 nonclinical, full-time staff per full-time physician.

Both studies were co-funded by Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative and The Commonwealth Fund.

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May 14, 2009

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Lawrence P. Casalino, M.D., Ph.D., Sean Nicholson, Ph.D., David N. Gans, M.S., Terry Hammons, M.D., Dante Morra, M.D., M.B.A., Theodore Karrison, Ph.D., and Wendy Levinson, M.D.

May 14, 2009

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