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January 28, 2010

The Honorable Tony DeLuca
Chairman, House Insurance Committee
115 Irvis Office Building
Harrisburg, PA 17120

Re: Testimonial for Legislative Hearing on Anti-Fraud Legislation

Dear Representative DeLuca:

On behalf of the over 4,800 members of the Pennsylvania Academy of Family Physicians (PAFP), I ask that this letter serve as written testimony at the hearing of the House Insurance Committee in Blue Bell, Pennsylvania on Thursday, January 28, 2010. The PAFP applauds you and your Committee for holding hearings on the very crucial issues related to fraud and efforts to prevent it.

The Committee in its first two hearings on these matters conducted in 2009 heard testimony from insurers and those who represent the insurance industry on their opinions on the legislation before the Committee, as well as their company and industry experiences attempting to combat fraud, particularly in the healthcare insurance market. Some of those ideas that have been proffered we agree with, and others we would like to provide another side to balance the Committee's perspective, particularly from the family physician point-of-view.

System Complexity and Statistical Extrapolation

The PAFP agrees with a prior testimony provided to the Committee that the process of billing for services by a provider is unfortunately complex. While family physicians code and bill for a full gamut of services they provide, generally speaking, they most often bill insurers for payment of services for their patients under 10 commonly used billing codes, better known as "evaluation and management" (E&M) codes. These 10 codes are then broken down into 5 levels, starting from a "Level I" office visit demarking the least amount of time and complexity in diagnosis and treatment with the patient to a "Level V", the most time with the patient.

Furthermore, family physicians bill for thousands of patient visits in a year for multiple insurers and patients with different insurance products. The process becomes even more complex because each insurer, usually with multiple product lines, has its own set of

restrictions and requirements on what they will and will not pay for. Accordingly, family physicians must adhere to all of these administrative requirements that include: documentation, understanding what insurance product the patient has and what will be covered, prior approval for treatment, complex and detailed medical policies, administrative bulletins, utilization guidelines, etc. So what begins as set of codes with variances for the level of time and difficulty depending on the conditions that are present at the time of the visit, quickly balloons to a complex struggle in the art of coding to match each insurer's administrative requirements in order to receive payment for the care that has been provided to the patient by the family physician.

In contrast, what perplexes many family physicians that have been investigated for potential "fraud" by an insurer is that from this complex system of over thousands of patient visits a year, is the relative simplistic device of statistical extrapolation used by the insurer to determine how much a family physician should pay back to the insurer in the event of a billing error. This process takes a small statistical sample of the global billing behavior of a physician, usually 20 to 30 records for a given period, and if an error in billing was detected, the insurer multiples the error rate derived from the small subset by the global billing period, determines a price tag and sends a letter demanding payment. These types of efforts to combat potential "fraud" are very far from the racketeering fraudulent crime rings that have rightfully been prosecuted and shared as examples with the Committee thus far.

From the family physician perspective, the amounts are much smaller in comparison and can be detrimental to a small family physician office that receives such a demand letter. In order to fight this, they often must unfortunately turn to outside legal counsel and pay for it out of pocket. While again, the PAFP certainly does not condone fraudulent activities, the kinds of examples described for the Committee thus far in the healthcare setting have not been based on honest mistakes of the smaller physician and provider offices in which a pattern of potential billing errors by a family physician are many times improperly equated with fraud.

Compounding this frustration, we know of instances where the insurance company provides billing guidance to a family physician when they make attempts to determine if a treatment will be paid, only to have the insurer turn around at a later date and deny the very treatment they authorized, and demand payback. A real life example of this activity occurred to a rural family physician in the state, contacting a large non-profit insurer also domiciled in the Commonwealth. The rural family physician inquired to find out if massage therapy that was provided in the physician office for patients by a massage therapist, would be a covered service. The response to the family physician was, "yes."

Following the advice of the insurance company, the family physician billed for several years of treatment. That was until the day that the same insurer that previously told the

family physician that it was alright for her to bill for the services, now changed its mind, and demanded payback in an amount that would put the physician and his practice in a rural part of the state out of business. This example does not represent some hardened criminal attempting to bilk the system, or some crime ring that we all agree should be sought after and prosecuted. To the contrary, this case example is just the opposite: an honest rural family physician trying to provide the best care for his patients, making the good faith effort to ensure that his business practices are sound, who ended up getting punished for the insurance company's mistake.

Additionally and in contrast to the extrapolation process, is the fact that by their own accounts provided to this Committee, multiple health insurers in the state have developed sophisticated mining data to monitor the billing activity of their provider panels. With these kinds of sophisticated data oversight devices they have implemented, we question why such a simplistic statistics sampling method should be needed with such sophisticated software programs. The PAFP certainly believes that fraudulent activities should be tackled regardless of the size, we are hopeful that the referenced mining software will soon aid in not only the ability to provide quicker feedback mechanisms between insurers and their provider panels, but also aid in separating the difference between fraud and honest billing mistakes caused by complicated and ambiguous coding rules and insurance carrier policies.

Unfortunately in prior testimony to the Committee, some in our opinion have attempted to trivialize the difference between an honest billing mistake that occurs over a period of time versus committing a fraudulent act as fodder for academic debate exclusively. Speaking on behalf of family physicians who have received letters for insurance payback amounts that would wreck their practice and their livelihood for what ultimately constituted billing mistakes, we heartedly disagree with this preconceived approach. Frankly, it is this type of sentiment that is at the root of our concern with some of the elements of the bills being considered by the Committee. The simple fact is, that while both insurers and providers do their best to conduct themselves in an honest business practices, unfortunately with the inherent complexity of the system, mistakes happen. And, we want the Committee to know that mistakes that occur over a period of time do not ever constitute fraud.

Misplaced Systemic Incentives and the Patient Centered Medical Home

We further agree with one prior testimonial to the Committee from a nonprofit insurer that the current systemic incentives for providers are misplaced and unsustainable. That is, the system is based upon and rewards numbers of procedures and numbers patient visits rather than rewarding quality. Whether this leads some bad actors to consider fraudulent activities as a way to enrich themselves we cannot answer. However, from the family physician and primary care medicine perspective, we believe that system change –

predicated on a strong primary care medicine foundation - can simplify the billing process and reward physicians and providers on the basis of patient quality rather than the quantity.

To this end, the PAFP applauds the many insurers in the Commonwealth who have worked with the Chronic Care Commission and the Improving Performance In Practice organization (of which the PAFP is a co-participant) in demonstration models in practices in all regions throughout the Commonwealth. The 170 practices participating throughout the state in these demonstrations are working to reengineer their primary care practices to better address the needs of both acute care patient visits and patients with chronic diseases alike. The PAFP believes that through these participating practices and with the financial help and support by the participating insurers, the Commonwealth is well on its way towards providing needed data on the value of the patient centered medical homes for patients, physicians and practitioners, insurers, and rate-payers alike. These types of efforts will lead to better outcomes and a much better system of payment to primary care physicians as they redesign their practices in cooperation with the insurance community to create an environment that incentivizes and rewards patient quality over quantity.

House Bill 2154

The PAFP understands the intent of House Bill 2154 is to provide insurer-to-insurer immunity for communication on potential fraud. However, HB 2154 does much more that than this by lowering the standard under the existing immunity protections from "good faith" to "actual malice." Additionally, HB 2154 wipes out important definitions in existing law such as – "absence of bad faith"; "absence of fraud"; and "fraudulent insurance act" – which provide contextual meaning with regards to what it, and what is not, protected under the immunity veil.

The PAFP cannot speak to the other insurance contexts outside of the business practices of healthcare insurers. Therefore, from a tow truck operator insurance business paradigm, this type of immunity protection may be warranted as one prior testimony used as an example. However, from the health insurance line of business, we must ask if this legislation is really needed?

One testimony to the Committee by a national insurance fraud non-profit representative noted that insurer-to-insurer immunity was needed because insurers were reluctant to share potential fraud with law enforcement for fear of prosecution. However, two separate testimonies of Pennsylvania domiciled health insurers provided to the Committee, provided specific statistics on how many cases they reported to law enforcement, how many were prosecuted and what the recoveries were in those examples.

Further, under the existing law, health insurers are already permitted to some degree talk to one another and report suspected fraud under the good faith standard of immunity to a national nonprofit fraud detection agency that is financially supported by the insurance industry, the state Insurance Fraud and Prevention Authority and others. Frankly, from our perspective with specific regard to the health insurance business, this does not represent an attempt to solve a problem, but to tilt playing field of immunity advantages to the direction of the insurers.

For these reasons we would ask the Committee to at a minimum retain the aforementioned definitions in current law. Further, we believe that health insurers should be excluded from the lower standards of proof permitted under HB 2154 and the current good faith standard intact should be retained.

House Bill 1750

With regard to the provisions of HB 1750 that require additional reports by insurers on fraud prevention efforts, we will defer at this point to those who are directly affected by these changes. However, should the Committee chose to move forward on HB 1750, the PAFP asks that the immunity granted under Section 1161 on page 30, line 3 of the bill be clarified and applicable only to cases where there is credible evidence that insurance fraud or other criminal offenses involving fraud has occurred.

Thank you for the opportunity to provide this written testimony. Should you have any questions, please contact me direct, or the PAFP VP of Government Affairs, Andy Sandusky at 717-571-6647 or asandusky@pafp.com.

Sincerely,

Madalyn Schaefgen
PAFP President