Approved 4-6-90
Date

MINUTES OF THE Senate COMMITTEE ON Labor, Industry and Small Business.

The meeting was called to order by Senator Salisbury at
Chairperson

9:00 a.m./p.m. on April 2, 1990 in room 527-S of the Capitol.

All members were present except:

Senator Strict

Committee staff present:

Jerry Ann Donaldson, Legislative Research Department
Jim Wilson, Revisor of Statutes Office
Phil Lowe, Committee Secretary

Conferees appearing before the committee:

Jerry Slaughter, Kansas Medical Society
Terry Leatherman, Kansas Chamber of Commerce and Industry
Richard Hubbard, INTRACORP, Overland Park
Chip Wheelen, Kansas Medical Society
Robert Anderson, Director, Division of Workers Compensation
Lori Callahan, American Insurance Association

The meeting was called to order by the Chairman, Senator Salisbury, for the purpose of continuing the hearing on Substitute HB 3069.

Sub. HB 3069 - concerning the workers compensation act, relating to the administration thereof and the provision of benefits thereunder.

The first conferee, Terry Leatherman, KCCI, said that the House amendment their Industry finds most objectionable is granting the right of first choice of physician to the employee. He stated that employees make no contributions to premiums, pay no deductible charges, or pay any money for medical care provided. Since the state requires employers to pay all costs for this system which benefits employees, it seems only fair to arm the employer with all the cost saving tools possible, as long as the care for the injured worker is not affected. Mr. Leatherman objected to another amendment that was adopted by the House Committee of the Whole to make appointments to the advisory panel to be made in such a manner that the gender of members is representative of residents of the state and the appointing authorities shall consult each other to accomplish that end. He urged the committee to leave it up to the KCCI to make the selection of who was to serve on the advisory panel. (See copy of his written testimony **Attachment I**).

The next conferee, Jerry Slaughter, Kansas Medical Society, said they had no problem with the amendment that changes the word "physician" to "health care provider". He stated their Society has no position on the House Committee of the Whole amendment that appointments to the advisory panel shall be that the gender of members is representative of residents of the state. In regard to the amendment on the medical fee schedule he said they were working with the legislature and the Director of the Workers Compensation in the development of a reasonable medical fee schedule.

Richard Hubbard, INTRACORP, said they support the establishment of a medical fee schedule, but if this bill is enacted it would also establish fees for vocational rehabilitation services and would establish an advisory panel which would determine fees for several rehabilitation centers throughout the state. Mr. Hubbard said he is a vendor and would request that since there are several vendors throughout the state they would prefer to have representation on the panel.

Chip Wheelen, Kansas Medical Society, spoke in regard to the definition of health care provider and said it does not interfere in any way with health and accident insurance. He stated that if some insurance workers compensation companies utilize forms that incorporate the word "physician" than those forms can be eventually replaced with the term "health care provider."

Robert Anderson, Director of Workers Compensation, said that the family physician may not be the appropriate person to refer an injured worker to. He said there exists a statuatory provision for changing physicians following a preliminary hearing.

Lori Callahan, American Insurance Association, said their recommendation of who should treat an injured worker often is the most beneficial since they handle workers compensation cases everyday and know what sort of help injured workers need and have the knowledge of who performs that kind of work.

The Chairman stated that the hearing on Sub. HB 3069 was now concluded and ready for discussion and possible action on the amendments recommended by the conferees.

Senator Morris moved to amend Section 3(B) on page 7, 31 to 37 which eliminates alternating nominations to the advisory panel. Senator Oleen seconded the motion. The motion carried.

Senator Sallee made a motion to amend the bill in Section 3(B), page 8, by deleting the word "gender". Senator Morris seconded the motion. The motion carried.

Senator Oleen moved to amend Section 3(D), page 8, by striking all of subsection (D), which would eliminate compensation, subsistence allowances, mileage and other expenses for members of the advisory panel attending meetings of the panel. Senator Daniels seconded the motion. The motion lost.

Senator Oleen made a motion to amend Section 3(D), page 8, to disallow the word "compensation" but to allow subsistence and mileage. Senator Daniels seconded the motion. The motion carried.

Senator Petty moved to recommend Sub. 3069, as amended, favorably for passage. Senator Feleciano seconded the motion.

Senator Morris made a Substitute motion to delete Section 3, (12) (b), page 11, lines 8 to 12 to allow the injured worker to select the health care provider of his choice. Senator Sallee seconded the motion. The motion failed.

The committee voted on the original motion by Senator Petty and second by Senator Feleciano to recommend favorably for passage as amended Substitute HB 3069. The motion carried.

The meeting was adjourned.

GUEST LIST

COMMITTEE: Senate L+I & S. bus Comm DATE: 04/02/90

NAME	ADDRESS	ORGANIZATION
Robert A. Anderson	Topeka,	Director, Div. of WIC.
Chip Wheelen	Topeka	Ks Medical Soc.
Jerry Slaughter	"	" " "
Terry Leatherman	"	KCCI
Charles Simha	Topeka	KS Foundation for Medical Care
Richard Hubbard	Overland Park	INTRAWORP
John Ostrowski	Topeka	AFL-CIO
M. Hauver	"	Capital-Journal
Richard Cox	"	DOA
Bill Curtis	Topeka	Ks Assoc. of School Bds.

KANSAS DEPARTMENT OF HUMAN RESOURCES

DIVISION OF WORKERS COMPENSATION
600 Merchants Bank Tower, 800 SW Jackson
Topeka, Kansas 66612-1227
(General Information: 913-296-3441)

Mike Hayden, Governor

Ray D. Siehndel, Secretary

296-4000 Director's Office
296-2050 Rehabilitation
296-2996 Claims Advisory
296-3606 Self Insurance
296-7012 Law Judges

COPY

FOR YOUR INFORMATION

March 30, 1990

The Honorable Alicia L. Salisbury, Chairperson
Senate Labor, Industry & Small Business Committee
State Capitol, Room 143-N
Topeka, KS 66612

Re: House Bill 3069

Dear Chairperson Salisbury:

Thank you for allowing me to appear before your committee today to testify in support of House Bill 3069.

House Bill 3069 is a codification of the recommendations that I made to the House Labor & Industry Committee as proposed amendments to the Workers Compensation Act which will eliminate existing problems and reduce litigation and some compromise proposals by the Kansas AFL-CIO.

Although HB 3069 has 19 separate sections and proposes to amend 17 existing statutes; in 8 sections of the proposed legislation the only change is the term "physician" is changed to the term "health care provider."

Sections 1-3, 6, 8-12, 16 and 17 of the proposed legislation, HB 3069, are amendments to existing statutes [K.S.A. 1989 Supp. 44-501; 44-510c; 44-515; 44-516; 44-518; 44-519; 44-528; 44-5a04; and 44-5a18] to change the term physician to the term health care provider.

Section 2, of HB 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-508] to define the terms health care provider, utilization review, peer review and peer review committee.

These additional definitions are needed, if the proposed maximum medical fees schedule and utilization review measure proposed in Section 3 are adopted.

attachment I

3-30-90

Section 3 of HB 3069 is an amendment to an existing statute [K.S.A. 1989 Supp. 44-510] to provide that the director by rule and regulation establish a maximum fee schedule for medical, surgical, hospital, dental, nursing, vocational rehabilitation or any other treatment or services provided or ordered by health care providers and rendered to employees including costs and charges for medical records and testimony.

This section of the statute further provides that the director create an advisory panel to assist in the adoption of maximum fees and to annually review and approve the maximum fees; authorizes the director to hear and determine all disputes and prescribe procedural rules to be followed in the resolution of disputes; authorizes the director to investigate health care providers and health care facilities to assure compliance; and, authorizes development of utilization review procedures including show cause hearings if it is determined that a health care provider overutilized or ordered unjustified medical treatment.

Although the existing statute gives the director the authority, (and arguably the responsibility) to establish a medical fee schedule, I feel it is important that the enabling legislation be very specific and allow for the adoption of a fee schedule and utilization measures that will insure that medical care for injured workers is not more expensive than medical care for non-workers and that the fees and costs of services provided by those who health care providers refer patients to, or order tests and treatment from, are not more expensive than treatment for non-workers compensation injuries. It is also important that the medical providers are involved in initially establishing these maximum fees and in reviewing them on an annual basis. Another major consideration is that maximum fees must be sufficient to ensure availability of such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury. Finally, there must be a provision to allow utilization review and peer review, if needed. The proposed enabling legislation should accomplish all of those goals while helping to reduce rising cost for injured employees, employers and insurance carriers.

As a minor example, bills for copying charges of medical records are often received for $25 to $50 for a single sheet of paper. These expenses are often paid by insurance carriers without objection and the costs are passed on to the employer through premium increases. Injured employees, who order these records, may not initially pay for those charges, but will reimburse their attorney for these "costs of the litigation".

In August 1989, the task force to evaluate medical cost containment and fee schedules for workers compensation in Kansas issued their report. A copy of that report is enclosed.

The task force noted in the report that: All other insurance lines of business have implemented methods to control both medical utilization and individual fees. This means "cost shifting" could be taking place and workers compensation is paying the highest rates. Two actual examples gathered by the task force follow:

	Managed Care	Group Health	Champus	Workers Comp
Laminectomy	$1,625	$2,365	$2,714	$2,987
Ortho Office Visit	$ 20	$22 to $24	$ 25	$ 27

The task force received the most accurate data on medical costs and indemnity increases from the largest employer in Kansas - the State of Kansas. This data (attachment #4 marked as Exhibit A) is directly out of the claims department and Claims Manager George Welch reports the number of claims did not vary significantly during the time period covered by the table. These medical costs have increased by 97 percent over a 5-year period - compared to the CPI medical costs 32 percent to 34 percent over a 6-year period.

The Kansas State data is also important because we can analyze the percentage of medical costs compared to total costs. This indicates Kansas paid almost as much in medical costs as in indemnity. Or, 45 percent to 49.7 percent of the workers compensation payments are made for medical care. The National Council on Compensation Insurance has advised us this range should actually be 30 to 40 percent.

The state of Kansas has since created an office of Risk Management, entered a contract with a Topeka hospital on a trial basis before contracting on a statewide basis for managed care of their injured workers and has prepared a return to work policy, all of which should reduce costs. Based upon the 1988 medical payout figures and a 22 - 25 percent projected savings, the state of Kansas would save between $627,742 and $713,343 a year on medical cost under a maximum medical fee schedule.

The fiscal impact of employment of additional personnel and clerical support staff to implement and administer a maximum fee schedule would be as follows:

Salaries and fringe benefits for one Range 27C	$38,883
Salaries and fringe benefits for two Range 24	64,594
Salaries and fringe benefits for two Range 13	39,480
Telephone and Postage	9,500

Supplies	4,000
Medical fee schedule book (printing 10,000 copies)	170,000
Telephone system and installation	4,500
Maintenance and Repair	2,500
Travel and Subsistence	6,000
Furniture, Equipment and Mobile file system	65,230
Computer cost, including programming and related charges	64,496
Allocated Overhead (DHR)	14,250
TOTAL	**$483,433**

Although the start-up cost for this new section seems high, those that pay this assessment are very much in support of its adoption. After the first year the cost would be on salaries and benefits, etc; however, the printing cost would be reduced and any cost for printing would be reimbursed by charging for the printed schedules. Finally, if a medical fee schedule and utilization review are adopted as medical cost containment measures in Kansas, employers, insurance carriers and injured workers, based upon national data, can expect the overall cost of medical care in Kansas for injured workers to be reduced by an average of 22 to 25 percent. Based upon the 1988 statistical data of actual costs paid for medical care for injured workers, that would mean an annual savings of $13 million to $17.6 million.

In 1965, 12 states used fee schedules; by 1985, 17 states were using them. In 1989, 23 states had fee schedules, 2 others had schedules pending, and several more were considering their adoption, according to the Workers Compensation Research Institute. Today, 31 states have some form of legislatively authorized fee schedule. See Chart Exhibit 1.

Section 6, of HB 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-510g] to provide that if an employee is receiving unemployment compensation benefits, no temporary total or temporary partial disability compensation shall be payable under this section.

The amendment will prohibit an injured worker from receiving both temporary total disability benefits and unemployment compensation during the same weeks. Although this has certainly been the exception and not the rule, employers across the state have raised this issue when they realize they are paying for both of these benefits for the same weeks. This amendment should help encourage employers to voluntarily provide benefits when they know there is no longer a loophole in the system that provides an employee to earn more while they are off work than when they were working.

Section 7, of HB 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-512a] to provide that a penalty for each past due medical bill shall be assessed in an amount equal to the larger of either $25 or a sum equal to 10 percent of the amount past due on the medical bill. The statute now provides that the penalty for each past due medical bill is $25.

This is a much needed amendment. As the statute now exists, there is no incentive to file a 44-512a demand for payment of a court-ordered medical bill, as the civil penalty is only $25. Likewise, an employer or insurance carrier in theory will not fear not paying a $5,000 or $10,000 bill if the only penalty is $25. However, with a potential civil penalty of 10 percent of the bill amount, medical bills will be paid more promptly.

Although the Act protects the injured worker from being initially sued for payment or collection of the medical bills, this amendment should keep the injured workers from receiving collection notices and when and if they do, there will be a more effective remedy to provide for future payment.

This amendment should help reduce the overhead of medical providers and insure prompt payments, which should help reduce the cost of medical care in Kansas.

Section 13, the amendment provides for the ability to receive temporary total disability payment, when evidence is produced to justify the decision from the date of accident; and eliminates the need to file more than one 7-day notice letter.

Section 14, of HB 3069, is an amendment to an existing statute [K.S.A. 44-551] to provide that a director's review of a preliminary award under K.S.A. 44-534a shall not be conducted unless it is believed the administrative law judge exceeded his authority in entering the award. The proposed legislation further provides that director's orders on review of preliminary findings shall be issued within 30 days of oral argument or submission of the case on the record and any other director's orders shall be issued within 90 days of oral argument or submission of the case on the record.

The statute does not now have a time limitation for issuance of a director's order on review. K.A.R. 51-3-5a now provides that a director's review of a preliminary award shall not be entertained except if it is believed the administrative law judge exceeded the authority of an administrative law judge in entering the award.

The "backlog" that had existed at least since March 1985 (according

to Division memorandum) was finally eliminated January 1, 1990, after an 18 month effort. Although I am confident that there will never be another judicial backlog at either the administrative law judge level or the director's level during the time I remain as director, I realize I serve at the pleasure of the Secretary of Human Resources, and as an unclassified employee, this position can change with administrations. Because of that there is a need to insure that the parties have some statutory remedy if another judicial backlog at the director's review level should occur.

Under the proposed amendment, if an order wasn't issued on a preliminary award within 30 days, or final award within 90 days, a party could seek civil relief through mandamus. The amendment also provides for payment of permanent partial disability after 90 days on review.

Section 15, of HB 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-556] to provide that any party may notify the director if a district court has not issued judgment on review within 60 days after submission so that the director can request the district court judge to render a decision. The statute now provides that only the appealing party shall notify the director.

Section 15 further provides that when the compensation paid during pendency of review where the benefits awarded by the director or district court are ultimately reduced by decision on appeal and the balance due the employee exceeds the amount of reduction, the employer shall receive a credit for all amounts paid in excess of the benefits the worker is entitled to as determined by the final decision on appeal. The credit to the employer is applied to the any lump sum due under the award and any additional credit is applied against the last compensation payments to the employee by reducing the period of time over which payments are made without interrupting payment of benefits after the decision.

The first change under Section 15 would allow <u>any</u> party to have their appeal to the district court decided in a timely manner by having the director notify the district court judge it has been over 60 days. Under the current statute, parties fear being labeled as the "appealing party" that has questioned the timeliness of the district court review.

The second change would allow the employer or insurance carrier to take a credit for any payment of temporary total, partial or total disability or permanent partial or total disability after a district court has reduced or disallowed some compensation, if that credit can be taken from a lump sum due and owing the claimant without stopping or reducing the weekly compensation amount. In

those cases where the lump sum would not be enough to take the credit from, the credit must be taken from the last weeks of compensation due under the district court or appellate court award.

This amendment will prevent those cases where the claimant receives a "windfall" because of the court decision that provides that the only way to get reimbursed is from the Workers' Compensation Fund and does not allow a credit from the worker's future compensation payments.

This amendment will encourage employers to voluntarily pay compensation prior to a court order and insure that all a claimant gets is just compensation, no more, no less, and will insure that neither side is penalized when it can be avoided.

This amendment should reduce the amount of money that is reimbursed by the Workers' Compensation Fund each year which should have an effect on the cost of the system. This amendment will also express how credits are to be taken and avoid the current methods, attempted by respondents which end up being litigated and subject to K.S.A. 44-512a penalties.

Finally, this amendment would legislatively change the judicial determination in Johnson v. Tony's Pizza Service, 232 Kan. 848, Syl.1, 658 P.2d 1047 (1983) which holds where a workers' compensation award is reduced or totally disallowed by a district or appellate court, K.S.A. 1982 Supp. 44-556(d) provides the sole means by which the employer and its insurance carrier may be reimbursed for any excess payment of compensation. Said statute provides that such reimbursement shall be from the Workers' Compensation Fund upon certification of the amount by the Director of Workers Compensation and is not limited in application to reimbursement of overpayment which exceeds the balance due claimant on the award as modified.

In Johnson v. Tony's Pizza Service, the Workers' Compensation Fund's brief was devoted to the policy argument that the claimant should not receive a windfall to which he or she is not entitled except when he or she would have to dig into his or her own pocket to repay the overpayment. The court noted and agreed with the claimant's counsel that the policy argument would be better addressed to the Legislature as its implementation would entail substantial statutory modification. Id. at 852. This amendment is that substantial statutory modification.

In conclusion, I submit that these proposed amendments should eliminate some existing problems and reduce litigation. If the maximum medical fee schedule is adopted, it should reduce the costs

of the workers compensation system which will help reduce workers compensation insurance costs. The domino effect is that workers will be retained in their jobs where drastic premium increases would cause layoffs and business closings. Industry will be encouraged to expand or come to Kansas which will help the economy.

These minor amendments and the maximum medical fee schedule will promote health care cost containment and efficiency in the system, without reducing justified benefits, and I encourage you and all committee members to pass this proposed legislation on to the entire senate for their consideration along with your strong recommendation that the HB 3036 be passed.

In the House, there were 4 floor amendments, three which of passed. The first, at page 10, line 32 by Representative Gomez to insert other qualifying language. The second, at page 10, by Representative Hensley, to change from employer choice to employee choice. The third, by Representative Gross, to add gender balance to the panel. The only objection I would see is that studies have shown employer choice coupled with a medical fee schedule and utilization review is the most effective cost containment measure.

Thank you again for allowing me to appear before you.

Yours truly,

Robert A. Anderson

Robert A. Anderson
Workers Compensation Director

mr

Enclosures

pc: Each Committee Member
Secretary Ray D. Siehndel

Report of:

Task Force to Evaluate Medical Cost Containment and Fee Schedules for Workers' Compensation in Kansas

August, 1989

Throughout this decade, public attention has focused on the subject of escalating costs of medical care in Kansas. Only recently, however, has much attention focused on the segment attributable to workers' compensation.

Having had some instances of success in restraining costs of group health insurance — and fearful that unrestrained workers' compensation medical costs were soaring out of control — several groups urged the Kansas Department of Human Resources to explore medical cost containment for workers' compensation in Kansas.

In the fall of 1988, the Workers' Compensation Division of KDHR responded by inviting various parties to form the nucleus of a task force to evaluate medical cost containment in general and fee schedules in particular. Jim Schwartz, consulting director of the broad-based Kansas Employer Coalition on Health, agreed to serve as chairman. The following people eventually participated in the task force:

NAME	COMPANY
James P. Schwartz Jr., Chairman	KS Employer Coalition on Health, Topeka, KS
Robert A. Anderson	KS Dept. of Human Resources, Work Comp Div.
Gary Caruthers	Kansas Medical Society, Topeka, KS
Margaret J. Griffith, R.N.	HealthCare CostControl, Inc., Olathe, KS
Frederick L. Haag	Foulston, Siefkin, Powers & Eberhardt, Wichita, KS
Wayne Kitchen	KPL Gas Service, Topeka, KS
Neal A. Shank, D.O.	Consultant, Kansas City, MO
Judy Shorman	Fortis, Inc., Shawnee Mission, KS
John J. Bryan	Bryan, Lykins, Hejtmanek & Wulz, P.A.
John P. Hawkins, CPCU	Commercial Insurors, Inc.
Michael E. Russell, MS, CRC	Intracorp
George Welch	State of Kansas Employees
Pam Kincaid, R.N.	St. Paul Property & Casualty Co., Overland Park, KS
J. Patrick Kapsch	Liberty Mutual Insurance Co., Overland Park, KS
Gordon H. Preller	Schroer, Rice, P.A.
Michael Repp, D.C.	Chiropractor
Don Kosmicki	Deffenbaugh Industries, Inc., Shawnee, KS
Michael R. O'Neal	State Representative, Hutchinson, KS
Philip Godwin, M.D.	Physician
Chris Miller	Attorney, Lawrence, KS
Kevin Flattery	Work Capacities, Lenexa, KS
Tim McHugh	Intracorps
Bob Ream	Boeing Military Airplane Co.
John Wertzberger, MD	Physician
William T. Knickerbocker	Fred S. James & Co.
Rob Hodges	Kansas Chamber of Commerce & Industry, Topeka, KS
Susan J. Mattich-Pedersen	Crawford Risk Management Services, Kansas City, MO

The task force met four times in Topeka between November, 1988 and May, 1989.

From the start, most of the discussion centered on whether and how the State of Kansas should implement a schedule of fees for Kansas doctors and hospitals providing care to patients insured by workers' compensation. Division of Workers' Compensation Director Robert Anderson made clear that the Department has statutory authority to establish such a list of maximum fees for various medical procedures. A primary purpose

of the task force was to illuminate reasons for proceeding with such a schedule or for refraining from doing so, perhaps in favor of other remedies.

The task force never achieved a consensus on the question of whether or not to recommend implementation of a fee schedule. Clearly there were many viewpoints present, with varying economic consequences of such a choice.

Notwithstanding differences on the fee schedule issue, task force members appeared united in the opinion that improved control of health care utilization is a desirable and heretofore overlooked element of managing workers' compensation costs. In other words, health care costs are believed to be a function of the frequency and intensity of their use, and therefore a professional program of peer review should be helpful in reducing unnecessary hospital days and treatment modalities. No recommendations were made by the whole committee on methodology, but it seems clear to the chairman that sources of utilization review are widely available to all purchasers of W.C. insurance and can be applied to most any such product. Education must be considered a key factor in overcoming the inertia of the purchasing community in this regard.

Besides utilization, a key factor influencing cost of health care is price. Price is currently not controlled for workers' compensation in Kansas to any significant degree or in any systematic manner. Because the provision of workers' compensation treatment is highly regulated, competitive influences on prices have been perceived as minimal. Proponents of fee schedules generally argue that the regulatory model should be more complete, as it is in 24 other states, by including a ceiling on fees. Opponents of fee schedules argue that competitive relief is available to W.C. insurers and employers (particularly through their authority to assign a treating physician) and that such relief is simply underutilized.

Of interest to some students of these issues is the widespread failure of competitive forces to restrain medical costs for health care generally. The question for these students is whether fee schedules for workers' compensation might generate an experiment to suggest whether a more highly regulated model of health care provision might be warranted for wider application.

Because the task force could not reach agreement on whether or not to recommend a fee schedule, the chairman appointed two sub-committees to write reports: one favoring a fee schedule* and one opposing. Those reports follow and conclude the work of this committee, barring a decision to reopen these issues.

Task Force members are to be commended for taking time from their schedules to help shed light on this important public policy issue. The Department of Human Resources, whatever decision it ultimately makes, will enjoy benefit of having had many facets of the issue exposed to debate and of having input from a broad spectrum of observers.

Report by Sub-committee
Opposing
Implementation of Fee Schedules for Workers' Compensation in Kansas

by John Wertzberger, M.D.
Phillip Godwin, M.D.
Mark Saylor, M.D.
Gary Caruthers

1-12

The Case for Not Implementing A Workers Compensation Fee Schedule in Kansas

For the past several months, a task force has been studying the issues surrounding the implementation of a workers compensation fee schedule in Kansas. Concerns have been raised about the costs of workers compensation and the seemingly larger increases in medical costs compared to increases in other components of the worker's compensation system. Proponents of a fee schedule have pointed to other states' experiences and have concluded that implementation of a fee schedule will reduce workers compensation costs from 15-40%. We believe that it is premature to consider implementation of a fee schedule in Kansas. Advocates for a fee schedule have been looking at one large lump sum figure for medical expenses without specifically identifying the detailed components of the total. The amount of increase attributable to utilization must be isolated and then the discounted rate of increase should be compared to other meaningful trends such as the rate of increase in cost for medical provider liability insurance. Data from fee schedule states is inconclusive. We need more data on the differences in administrative procedures and coverages provided in fee schedule states. The differences may influence the estimated impacts identified with fee schedule states.

Implementation of a fee schedule may result in unwanted outcomes. Potential adverse outcomes include: increased administrative expenses, increased utilization of medical services, increased litigation, decreased availability of participating physicians resulting in decreased quality of care, upcoding or reporting of more severe injuries and increased costs for the program because low charging physicians raise their fees to the fee schedule amounts. The medical component of workers compensation accounts for approximately 40% of the total payout of the program. It is important to look at factors affecting the other 60% of the payout costs as well as the medical component. Cost issues must be addressed without affecting the quality of care provided to recipients. A fee schedule might lead to a medicaid type of program with decreased access to quality care. This has happened in the Medicaid program in Topeka where Pediatricians have decided not to accept new Medicaid patients because the program simply does not pay enough to cover the costs associated with providing the care.

One argument in favor of implementing a fee schedule is that it will simplify the payor's job of determining what should be paid for a certain service. We don't believe that this is sufficient reason to make major changes in the system.

We recommend that several other measures be addressed before considering the implementation of a workers compensation fee schedule in Kansas. They are listed below for your consideration.

1. Direct the Worker's Compensation Division to conduct an indepth study of procedures, diagnoses and fees paid. Identify aberrant practices and develop programs to modify any abuses. Target the most frequent procedures or diagnosis and the most expensive charges and develop programs to insure appropriateness.

2a. Contact the Kansas Foundation for Medical Care to discuss the possibility of developing a utilization review program and a preadmission/preprocedure certification program.

2b. Develop a participating physician program. Exclude physicians when practices fall outside a certain range.

3. Contact Blue Cross and Blue Shield to discuss possible administration of a Workers Compensation program, case management of potentially expensive cases and possible utilization of their fee schedule.

4. Encourage the development of managed care programs where feasible. Introduce competition into the system.

5. Focus on prevention and educational programs. Develop accident prevention and risk management programs, provide adequate staffing and training.

6. Develop specific physical standards for employment and hire accordingly.

7. Develop return to work and light duty programs.

8. Encourage claims payment review to insure appropriateness.

9. Study structured settlements through the purchasing of annuities, providing regular payments to claimants. There is the potential for reducing ultimate costs and eliminating administrative expenses associated with claims handling.

10. Study the development of dispute resolution process to reduce the costs of litigation.

11. Study the impact of low wages and lack of adequate health insurance in shifting costs to workers compensation.

12. Determine what impact the implementation of a Medicare Resource Based Relative Value Scale will have on other payment programs.

13. Consider reduction of minimum weekly benefits to encourage workers to return to work more quickly.

Comments have been made that providers charge more for workers compensation cases than for other cases. If this is true, is there any justification for it? Are there increased costs associated with workers compensation cases, such as increased administrative and paper work requirements and increased legal requirements including depositions or court appearances? This should be studied to insure that administration of the workers compensation program is as efficient as possible.

In summary, we believe that implementation of a fee schedule in Kansas is not justified. There are many other factors with significant potential for cost containment that should be considered first.

John Wertzberger, M.D.
Phillip Godwin, M.D.
Mark Saylor, M.D.
Gary Caruthers

Report by Sub-committee
Favoring
Implementation of Fee Schedules for Workers' Compensation in Kansas

by Judy Shorman
Wayne Kitchen
Pam Kincaid
Margaret Griffith
Mike Russell

1-15

WORKERS COMP TASK FORCE: SUB-COMMITTEE REPORT ON MEDICAL COSTS

Under the Kansas Workers Compensation Statute employers are required to provide, for injured workers, medical care that is "fair, reasonable and necessary". Employers, insurors, and audit companies are therefore in a position where they must determine what is "fair, reasonable and necessary". Unfortunately, we cannot assume that all bills submitted by medical providers and hospitals are "fair, reasonable and necessary". So the employers, insurors, and audit companies use their own methods to evaluate fees. Then the administrative law judges and state Workers Compensation Director are put in the position of assessing the situation and determining if the fees in question are "fair, reasonable and necessary". This scenario creates several problems:

1. No consistent data is being utilized to determine medical fees. Each employer, insuror, or audit company creates their own data base, using whatever bills are available to them to establish "reasonableness".

2. No statistically valid data is available for the judges and director to base their determinations of "reasonable and necessity" upon.

3. Increased litigation results because the only way in our system to resolve medical fee disputes is through hearings.

4. Adversarial relationships develop when an employer or insuror questions a medical bill and the medical provider continues to bill the claimant and pursue collections.

5. No Pre-Approval of Medical Care Fees between the provider and payor is required. Fee Reviews now take place retrospectively - after the medical treatment has been rendered - when the provider is expecting to be paid.

6. No method exists for Agreement on Medical Fees between all parties.

To put this issue of medical costs into a broader perspective, the task force has spent several months researching and hearing information on the topic of medical fees. The following points take this topic from a national perspective down to specifically Kansas Workers Compensation medical costs:

Nationally, the Wage Earners CPI documents medical care costs are rising much faster than all consumer services. In fact, medical services are up 41% over a six year period compared to all other consumer services being up 12%.

Kansas is in the North Central Region of the CPI and this region shows comparable increases. Medical care services are up 32% to 35% over the same six year period compared to 15% for all consumer services. (The group being cited is "wage earners" because this would be blue collar and clerical workers only - not all consumers - the group most similar to the Workers Compensation population. (See attachments #1 and #2.)

Another piece of data comes from the National Foundation for Unemployment Compensation and Workers Compensation. (See graph attachment #3.) In this graph we see a leveling off of Workers Compensation weekly wages compared to rising CPI medical costs.

The task force received the most accurate data on medical costs and indemnity increases from the largest employer in Kansas - the State of Kansas. This data (attachment #4) is directly out of the claims department and Claims Manager George Welch reports the number of claims did not vary significantly during the time period covered by the table. These medical costs have increased by 97% over a five year period - compared to the CPI medical costs (above) 32% to 34% over a six year period.

The Kansas State data is also important because we can analyze the percentage of medical costs compared to total costs. This indicates Kansas paid almost as much in medical costs as in indemnity. Or, 45% to 49.7% of the Workers Compensation payments are made for medical care. The National Council on Compensation Insurance has advised us this range should actually be 30% to 40%.

In our research, we identified these other sources of data which should be noted are <u>not</u> available: First, medical cost and indemnity history is developed by the Kansas State Insurance Department annually. This data is from all insurors who write Workers Compensation insurance in the state. This data has been requested but not received, and would only be through 1985. Secondly, the research done by the task force also indicated Kansas does not publish a state CPI. And finally, the Division of Workers Compensation reports annually on trends in medical and indemnity costs. However, this data is not reported in a consistent manner by employers and insurors and it cannot be validated.

Based on the above documentation of the medical costs problem, this sub-committee recommendation is to create a statistically valid and fair method for medical fees to be established and paid for under Workers Compensation. We believe there are four parties in Workers Compensation and all would benefit from this:

- <u>The injured worker</u> would not be harrassed by bill collectors while medical fees are disputed.

- <u>The Judges and Director</u> would not hear medical fee cases as frequently <u>and</u> they would have a consistent method for rulings.

- <u>Employers and Insurors</u> could decrease the time and money being spent on medical fee audits.

- <u>Medical Providers and Hospitals</u> could be paid more promptly as bill would not retrospectively be disputed.

1-17

Many other states (precisely 24) have already taken the initiative and created various types of Medical Fee and Utilization Guidelines. A leader in this has been the State of Washington, which reports medical cost savings for fiscal year 1988 exceed $9 million! (See attachment #5.) Other states, such as Michigan, have recently begun such programs (see attachment #6). Almost all states are struggling with managing increasing costs for Workers Compensation (see attachment #7). Our committee recommends we use some of the best methods created by other states as a basis to develop our own **Kansas Medical Services Management Program.**

We believe this **Medical Services and Fee Management Program** should include both utilization management and individual procedure fee guidelines. We recommend payors and providers be surveyed by the Division of Workers Compensation to assess what is currently being charged for and paid for under Workers Compensation. We also recommend Workers Compensation medical charges be compared to charges under other lines of insurance coverage, such as group health and managed care organizations. We can cite a number of reasons to proceed forward as quickly as possible with this project:

- All other insurance lines of business have implemented methods to control both medical utilization and individual fees. This means "cost shifting" could be taking place and Workers Compensation is paying the highest rates. Two actual examples gathered by the task force follow:

	Managed Care	Group Health	Champus	Workers Comp
Laminectomy	$1,625	$2,365	$2,714	$2,987
Ortho Office Visit	$ 20	$22 to $24	$ 25	$ 27

- Other lines of insurance create fee schedules based on the concept of "reasonable and customary" to determine payment of fees.

- Blue Cross Blue Shield recently cites the highest national increases in physicians fees were in greater Kansas City and they're taking aggressive steps to control further increases (see attachment #8).

- Specific fee guidlines would decrease time now spent on retrospective fee audits. This would expedite payment of medical bills. A new program could even require payment of bills within specific time frames.

- Fees submitted for payment should be in a standardized format, by procedure code. Medical bills should be itemized as they are required to be by group carriers, Champus, etc. One problem we encountered in studying this issue has been locating accurate data - because bills are not submitted by procedure code consistently, they cannot be totalled and analyzed.

- This is not a new and radical concept for Kansas. Kansas had a fee schedule which failed reportedly because there was not a method to update it. We need to update both new procedures and fees annually in a standardized program.

1-18

- Workers Compensation is a regulated system, and yet we don't have regulations to support the statuatory language regarding medical fees.

- Medical fees are not being disputed in a non-standardized method. Employers use whatever data they have and the Division of Workers Compensation mediates without any formal data.

- Medical providers are often angered by fee disputes, and they could decrease these disputes by participating in the creation of a **Medical Services Mangement Program.**

- Currently other lines of insurance pay 80% of reasonable and customary charges and the patient must pay the remaining 20%. If Workers Compensation fee guidelines are set at 100% payment by the employer, then providers should have an incentive to treat Workers Compensation claimants, not discouraged from it.

- We currently do not have a requirement for medical records to be submitted along with bills. This could also be corrected in a new program and would expedite resolution of claims and bills.

- Carriers now set reserves using whatever medical and indemnity data they have. A new medical services/fees program could make this process more accurate. This is important because medical fees are now half of all claims costs in Kansas, and there is no standardized method for estimating these costs. If the reserves aren't estimated accurately, then the financial stability of an insuror could be questioned.

- Adversarial relationships between all parties are created or worsened by medical fee disputes. Fee guidelines should decrease these.

- Retrospective audits of medical fees are now costly. Fee guidelines could be automated to decrease the cost of reviewing medical bills.

In conclusion, we believe a **Medical Services Management Program** could accomplish several goals. "Fair, reasonable and necessary," as applied to medical fees, could be defined by the Director, as Kansas statute states he may do. Consistency of fees could be achieved and efficiency of payments for fees could be enhanced. If medical costs are controlled then premium costs could be controlled and Kansas would be a better state to do business in. Abusers within the medical treatment system could be confronted in a standardized method. All parties should have improved relationships rather than adversarial relationships. And finally, Workers Compensation should not be "paying the tab" for other lines of insurance or the uninsured population.

1-19

FORTIS
Restoring Futures

Consumer Price Index

	CPI All Urban Consumers	CPI Urban Wage Carriers	CPI - North Central Urban Consumers City Size A	City Size B
1982	90.9	91.4	96.2	96.4
1983	96.5	96.9	100.1	100.0
1984	99.6	99.8	103.7	103.6
1985	103.9	103.3	107.2	106.4
1986	107.6	106.9	108.9	107.5
1987	109.6	108.6	112.7	111.6
1988	113.6	112.5	115.4	114.6

Notes

1982 to 1984 = 100 (base years)
Each year thereafter is the percent increase over the base years.

City Sizes: A = More than 1,200,000
B = 360,000 to 1,200,000
C = 50,000 to 360,000
D = Less than 50,000

"Wage Earners" means blue collar and clerical workers

North Central Region is: Kansas, Missouri, Nebraska, Iowa, Illinois, Ohio, Idaho, Michigan, Minnesota, North Dakota, South Dakota

8400 W. 110th Street
Suite #220
Overland Park, KS 66210
(913) 469-0712
FAX 913-469-0750

CPI Medical Care

	North Central All Urban (Size A)	North Central Wage Earners (Size A)	North Central All Urban (Size B)	North Central Wage Earners (Size B)
1982	92.3	92.3	92.9	92.9
1983	100.4	100.4	100.6	100.6
1984	107.4	107.4	106.5	106.5
1985	113.2	113.0	113.4	113.2
1986	121.2	120.8	120.6	120.2
1987	128.9	128.6	126.6	126.3
1988	134.9	134.9	132.3	132.4

	(Size C)	(Size C)	(Size D)	(Size D)
1982	94.5	94.4	92.5	92.6
1983	100.6	100.5	100.7	100.8
1984	104.9	105.0	106.8	106.6
1985	109.8	110.1	112.3	111.9
1986	117.7	117.9	120.8	120.1
1987	125.2	125.6	127.4	127.0
1988	134.5	135.3	131.9	131.6

Attachment

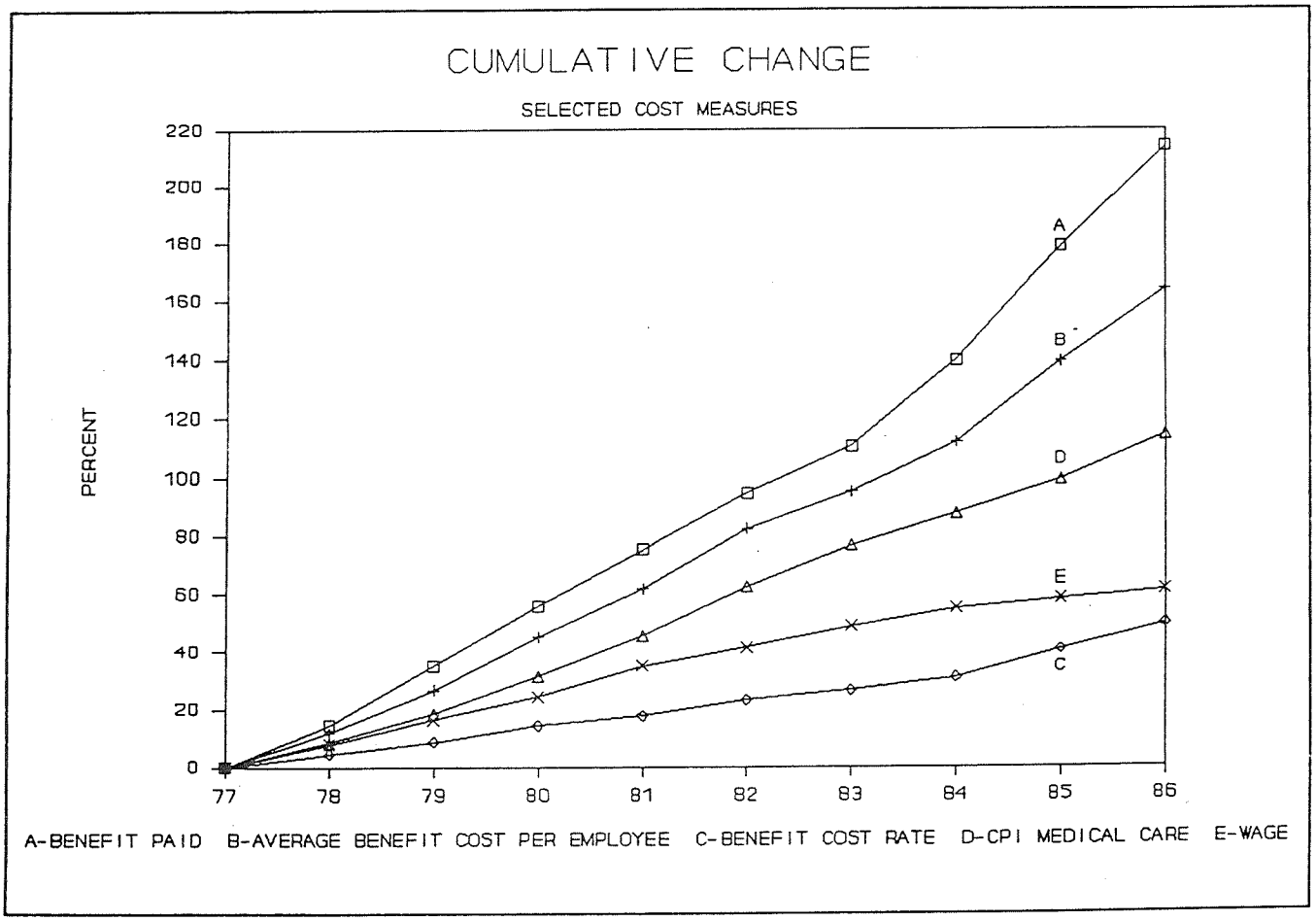
ISSN-0882

Suite 603—600 Maryland Avenue, S.W., Washington, D.C. 20024 (202) 484-3346

May 5, 1989 '89 W.C.-1

Fiscal Data For State Workers' Compensation Systems 1977-1986

As the graph below indicates, cash indemnity and medical benefits paid increased 213.8%, from $7.1 billion to $22.3 billion over the 1977-1986 period. The average benefit cost per covered employee increased 163.7% or $167 during the ten year period. The benefit cost rate (benefits paid as a percent of payroll) increased 49.5%. In the graph, we have included comparable changes in medical care costs and average weekly wages. Wage changes level off in the last two years. However, this was more than offset by the changes in medical care costs.



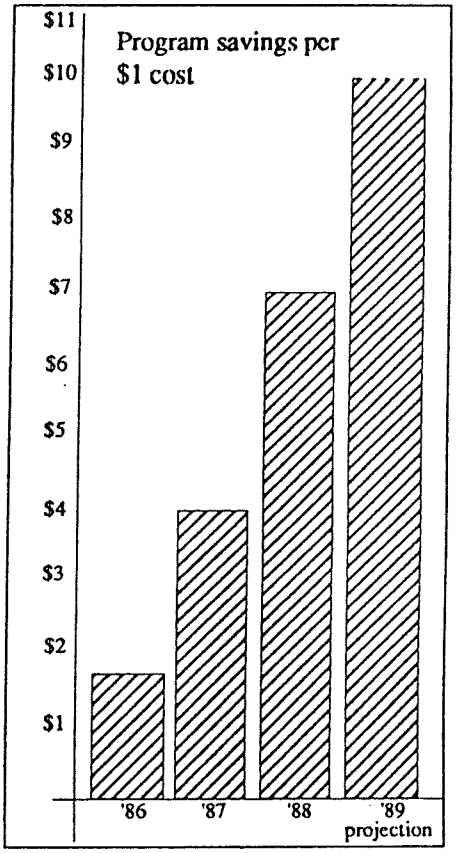
1-22

State Self-insured Fund
(State employees)

	1984	1985	1986	1987	1988
Disability	1,462,435	1,757,426	2,307,906	2,616,108	3,339,984
Medical	1,447,813	1,344,492	2,096,788	2,163,847	2,853,375
Total	2,910,248	3,101,918	4,404,694	4,779,955	6,193,359
Medical cost changes:		-7.6	155%	103%	131%
Medical as % of total	49.7	43.3	47.6	45.2	46.0

Summary

The Department of Labor and Industries' program to contain the costs of health care for injured workers and improve the quality of that care has produced major benefits for the workers and employers paying industrial insurance premiums. Savings in fiscal year 1988 were over $9 million, with a return of $7 saved for every $1 of program cost. For fiscal year 1989, estimated savings exceed $14 million, with a ratio of savings to cost of 10 to 1. Initiatives to improve the quality of care include the addition of a medical director for the department, and the establishment of guidelines for high quality care oriented toward returning injured workers to a productive life.



Background

In 1985, the Washington State Legislature directed the Department of Labor and Industries to design and implement programs to contain the rapidly growing costs of health care for injured workers. In a December 1, 1986, report to the Legislature, the department was able to report some initial success with fiscal year 1986 savings of $900,000, a return of $1.90 to $1 of program costs. The department's December 15, 1987, report described fiscal year 1987 savings of $5 million, with a ratio of $4 saved for every $1 of program cost. Savings for fiscal year 1988 exceed $9 million, with a return of 7 to 1. Total health care expenditures for injured workers in fiscal 1988 were $191.4 million.

When the cost containment program was initiated in 1985, substantial problems in the quality of care rendered to injured workers became apparent. A number of programs have been undertaken in this area, some of which are getting national attention for their contribution to improving services for injured workers.

Attachment #6

Michigan sets work comp health cost caps

By KARI BERMAN

LANSING, Mich. —New state regulations that cap payments for treatment of work-related illness and injury are expected to significantly reduce workers compensation costs in Michigan.

The new rules were accepted earlier this month by the Michigan Legislative Joint Committee on Administrative Rules, according to Larry Horwitz, executive vp of The Economic Alliance for Michigan, a non-profit organization representing business and labor that works for economic development in the state.

The rules, which take effect June 28, implement a 1981 law authorizing maximum fee schedules for health care services and introducing utilization review of health care claims for work-related injuries.

Although the Michigan Legislature approved the concept in 1981, various groups involved with workers compensation until recently were unable to agree on specifics of a new system.

The Michigan State Office of Health and Medical Affairs, which oversees workers compensation, last year asked the Economic Alliance to mediate discussions.

Representatives of health care providers, insurance companies, employers, unions and hospitals submitted their agreed-upon guidelines to the legislative committee for approval.

The compromise "represents a reasonable and balanced response to the sometimes conflicting concerns of recipients, providers, and purchasers of workers compensation health services," Mr. Horwitz stated in a news release.

Previously, Michigan required self-insured employers and insurance companies to pay for "reasonable and necessary" health service costs incurred by employees with work-related illnesses or injuries.

Workers compensation health care costs have been steadily increasing at an annual rate of 20%, leaping to $300 million in 1987, from $250 million in 1986, according to Mr. Horwitz. And 1988 expenditures are expected to reach $350 million, he added.

Mr. Horwitz conservatively estimates that the maximum fee schedule alone should save about 10% of payments for workers compensation health services in the first year of the new program.

"The caps on the fees should yield a savings of at least $35 million from July of 1989 to June of 1990 and that is without calculating the further savings that utilization control will bring," he said.

The newly adopted maximum fee schedule is based on a combination of data from other, existing price scales, according to Mr. Horwitz.

"We looked at fee schedules from other states, Blue Cross & Blue Shield PPO charges as well as commercial health insurance rates," Mr. Horwitz explained.

The utilization review program is designed to function on two levels:

- Technical review to determine the accuracy of a medical bill, making certain that it includes proper charges for the designated procedure.
- Professional health care review, required for claims either more than $5,000 or involving inpatient hospital care, will determine whether the treatment was medically appropriate.

However, any questionable claims can be submitted for additional professional utilization review, according to Mr. Horwitz.

The utilization review can either be conducted by the insurer or by a contracted certified health care agency. Professional review programs must be certified by the Michigan Department of Management and Budget and the Office of Health and Medical Affairs, Mr. Horwitz explained.

Roger Friez, vp of workers compensation claims at the Accident Fund of Michigan, the state's largest workers compensation insurer, covering 34,000 employers, supports the new reforms and believes that "they are a step in the right direction and will be effective measures for cost containment."

"Anything that reduces cost is something that we support. The maximum fee schedule will help because it will show exactly what is being charged at a set price," said John Leary, workers compensation rehabilitation claims administrator at Lansing-based Farm Bureau Mutual Insurance Co. of Michigan.

Also supporting a maximum fee schedule and utilization review program is Nancy Nowak, president of the Michigan Insurance Federation of Lansing, Mich., which represents 27 property/casualty insurance companies with offices in Michigan.

"The establishment of a maximum fee scale seemed like the most responsible thing to do for cost containment purposes. The scale is reasonable but I am sorry that it took so long for consensus," Ms. Nowak said.

"Employers are satisfied with the reforms because the set fees and utilization review will reduce the overcharging and bring a significant savings in the long run," said David Lewsley, manager of workers compensation at Chrysler Corp. of Highland Park, Mich., and chairman of the Michigan Self-Insured Assn. in Detroit.

Although often at odds with one another, organized labor representatives join employers in support of the workers compensation regulatory measures.

"We support the new rules but it was a long negotiating process. A lot of the issues were common sense things that with all of the different views took a while to resolve," said Tim Hughes, legislative director for the Lansing-based Michigan State AFL-CIO, representing 720,000 individuals and 68 labor unions.

While private health care providers and medical clinics have accepted the maximum fee schedule, a separate set of regulations providing for discounts will be applied to inpatient hospital services.

"The hospital sector was the last represented group to agree to the new reforms because they felt that their funds were already whittled away by government discounts and indigent care costs and a maximum fee schedule would not cover their expenses," Mr. Horwitz said.

Under the new rules, each hospital's inpatient charges will be subject to a mandatory discount, averaging 13% statewide. The discount will vary according to the individual hospital's cost, according to Mr. Horwitz.

"We were the last to accept the new regulations but it is a compromise package and we finally agreed to it," said a spokesman for the Michigan Hospital Assn. in Lansing, which represents an estimated 200 acute care hospitals in Michigan.

"It is difficult to predict how successful the new program will be but although we strongly opposed it initially, the hospitals basically accept the situation," the spokes said.

States facing increasing costs for workers' compensation

By BRANT HOUSTON
L.A. Times-Washington Post Service

Never has working for the state looked so dangerous.

And never has it been so expensive for taxpayers.

From Maine to California, the cost of injuries at the state workplace is soaring, forcing taxpayers to spend nearly a billion dollars a year on medical bills and lost wages for injured employees.

At the same time, future payments to injured state workers who recover slowly — or might never recover — could total billions of dollars nationwide in coming years.

Most states passed workers' compensation laws in 1912 or soon after. The laws were meant to help workers who were injured on the job to collect money for medical bills and lost wages quickly without taking their employers to court.

The cost of injuries at the state workplace is soaring, forcing taxpayers to spend nearly a billion dollars a year on medical bills and lost wages for injured employees.

Although private employers have become increasingly concerned over rising workers' compensation costs since the late 1970s, many states have only begun to realize the financial effect of employee injuries.

In fact, when The Hartford Courant interviewed workers' compensation administrators in all 50 states, officials in 12 said that they did not know, or could not readily say, how much injuries to their workers are costing taxpayers each year.

But 31 states showed significant increases, sometimes at a much faster rate than in the private workplace. For example, Connecticut's costs have increased by more than 1,000 percent in the past 10 years, triple that of private employers in the state.

Only two states, Louisiana and Arizona, reported their costs to be dropping.

The federal government keeps annual injury statistics for most private employers, which showed an increase of 5 percent in 1987, the latest year checked. But there are no such national statistics kept for state employees.

Many state officials said that injury claims by their employees have gone up in recent years, but they also attributed the increases in costs to a wide range of other factors, some of which are difficult, if not impossible, for them to control.

Among the reasons cited:

- Medical costs are climbing.
- Salaries are being driven upward by inflation.
- Benefits for some state employees are more generous than those for private employees.
- There are more people employed by state governments than ever before.
- More of those employees are aware of the money available from workers' compensation.
- States have been slow to establish programs to prevent injuries and hold down costs.

"Workers' compensation is tied to economic conditions and medical costs," said Donald LeMond, Missouri's risk and insurance manager, who oversees the handling of injury claims. "With the rate of medical inflation, it's going to go higher."

Like LeMond, officials in other states said that they were especially concerned about the increased medical expenses, noting that many states do not strictly limit the amount hospitals and doctors can charge for compensation cases.

"Private insurers in health care have put in cost containment," said Randy Waterman, assistant risk manager in Nevada. "Cost containment has not really been implemented for workers' compensation."

At the same time, some states pay their employees such low wages that their employees cannot afford high medical costs or health insurance. As a result, they charge illnesses and off-the-job injuries to workers' compensation, LeMond said.

"Health costs are so high, some workers are using compensation as a basic health plan," he said.

State and union officials said that for years state governments have neglected to take action that might stem the tide.

Few state governments have created accident-prevention programs, and fewer have put programs into effect that would enable state employees to return to work faster.

"Adequate staffing and training is the No. 1 problem," said James August, a health and safety specialist in Washington for the American Federation of State, County and Municipal Employees. "When you haven't recognized the problem, you aren't going to begin throwing money at it. So you're batting with one foot in a hole."

Ken Swisher, risk manager for the state of Michigan, said, "We didn't have risk management until November 1987." His job is to find ways to reduce the dangers of the workplace, and there are not that many Ken Swishers around.

"Safety takes a last seat in many states," said Smith, who is the risk manager in Maine but has no control over the workers' compensation program.

That means workers' compensation and risk-management offices are generally understaffed. States are reluctant to pay for programs unless they clearly save money, and that is difficult to prove. Workers' compensation costs are rising so fast that often the best that can be hoped for is to slow them, Smith said.

"Sometimes you see a decrease but never a sharp decline," he said.

Also contributing to rising costs, Smith and others said, is the lack of return-to-work programs for recovering employees. Because of that, they said, workers tend to stay out longer and accumulate more payments for lost wages.

Many state officials surveyed said that a lot of workers' injuries occur in state hospitals for the mentally ill or mentally retarded where workers must lift disabled patients or fend off assaults from violent ones.

LeMond said that injuries often can be predicted the day a person is hired.

"If you hire an obese, middle-aged woman to lift people, you are going to get an injury," he said. "But the government is the employer of last resort. We have no physical qualifications. We just check them (new employees) to make sure they don't have communicable diseases."

Connecticut, for example, has no specific physical standards for its health-care workers and correction officers. State officials have been working to develop standards that will not discriminate against the disabled.

State governments also might be paying the price for an aging work force more susceptible to injuries, particularly at state institutions.

"With a lot of our employees, their bodies are just wearing out," said Jean Ricker, director of human resources for the Department of Institutions in Colorado.

Aggravating the pain of the costs are the legal rulings on what qualifies a worker for compensation. Because workers' compensation is the result of social legislation, state administrators said, those who hear disputes over claims — commissioners, hearing officers or judges — tend to favor the worker.

"If a person comes in with a heart attack, it doesn't seem to matter that they weigh 350 pounds and have smoked for 40 years," said Judy Stewart, social insurance coordinator for 85,000 state employees in Pennsylvania.

Increased awareness of workers' compensation by employees and lawyers also is driving up state's legal costs. States have a difficult time measuring the cost because they generally use staff members from the offices of their attorneys general to fight rulings and questionable cases.

But Alaska's situation shows the kind of effect litigation can have. Donald Hitchcock, director of risk management there, said as much as $700,000 of the $5.2 million spent in fiscal year 1988 was for legal costs.

Some state officials, usually managers, also question whether the costs are a reflection of a change in attitude in America's work force. Those officials said that the workers believe they are owed jobs and benefits. They also said that there is a shirking of responsibility in the work force.

"It's not just workers' compensation. It's a national attitude about anything," Smith said. "If anyone gets hurts, it's someone else's fault."

Those kinds of attitude, sometimes coupled with poor morale within state bureaucracies, can only exacerbate the problem, officials said.

"We are dealing with a perception of workers' compensation as a benefit," said Kate Wood, the safety consultant for Oregon.

Wood said that even a mild scratch can turn into a claim of an injury. Or, she said, an employee might file a stress claim if they are criticized about their job performance.

But August and other union officials said it might be less an attitude change than workers' finally making legitimate claims.

"To a great extent people didn't file claims because they weren't aware of their rights," August said. "It's a classic case. Once people realized it was there, the floodgates opened."

Comparison shows two states have decrease in program costs

L.A. Times-Washington Post Service

This state-by-state comparison shows how costs for workers' compensation programs for state employees are generally rising. Only two states, Louisiana and Arizona, have been able to decrease costs. States are listed in the order of the amount they pay in workers' compensation claims.

Information for 12 states — Alabama, Colorado, Indiana, Mississippi, Montana, Nevada, New Mexico, North Dakota, Oklahoma, Vermont, Washington and Wyoming — was unavailable.

States have different record-keeping and accounting procedures, so figures are not always available for the same timespan. Listings are for calendar year, unless otherwise noted.

California: 190,000 employees. Costs: from from $82 million in 1983 to $142.2 million in 1987.

Ohio: 56,000 employees. Costs: from $86.8 million in 1986 to $93.5 million in 1987.

New York: 215,000 employees. Costs: from $50.1 million to $90.8 million in the last two years.

Connecticut: 52,000 employees. Costs: from $16.9 million in fiscal year 1984 to $44 million in fiscal year 1989.

Massachusetts: 75,000 employees. Costs: from $13 million to $30.1 million in last three years.

Pennsylvania: 85,000 employees. Costs: from $6 million to $28.7 million in last four years.

Illinois: 116,000 employees. Costs: from $23.7 million to $27.5 million in the last four years even though the Illinois Department of Mental Health was removed from budget last year.

Texas: 136,400 employees. Costs: from $9.8 million in 1983 to $22.5 million in 1987.

Oregon: 44,000 employees. Costs: from $7.4 million to $21.4 million in last five years.

Florida: 115,000 employees. Costs: from $11.6 million to $20.3 million in last four years.

Michigan: 65,000 employees. Costs: from $13.6 million to $18.2 million in last five years.

Louisiana: 83,000 employees. Costs: down from $24.8 million to $17.5 million in the last four years.

Rhode Island: 21,000 employees. Costs: from $7.3 million to $16.2 million in last five years.

Minnesota: 69,000 employees. Costs: from $10.6 million to $16 million in last three years.

Maryland: 72,725 employees. Costs: from $8 million in 1983 to $14.2 million in 1987.

New Jersey: 70,000 employees. Costs: from $12 million in fiscal year 1987 to $13 million in fiscal year 1988.

Georgia: 102,000 employees, including some county workers. Costs: from $7 million to $12.5 million in last four years.

Hawaii: 32,000 employees. Costs: from $5.6 million in fiscal year 1983 to $11.3 million in fiscal year 1987.

Maine: 15,221 employees. Costs: from $3.2 million to $8.3 million in last five years.

West Virginia: 37,839 employees. Costs: from $3.6 million in 1983 to $8.1 million in 1988.

Delaware: 30,000 employees. Costs: from $4.3 million to $7.8 million in the last five years.

North Carolina: 203,837 employees, including public schools. Costs: from $3.7 million to $7.4 million in last five years.

Missouri: 91,000 employees. Costs: from $4.4 million in fiscal year 1984 to $7.3 million in fiscal year 1989.

Arizona: 47,000 employees. Costs: down from $7 million to $6.9 million in last two years.

South Carolina: 59,000 employees. Costs: from $2.8 million in fiscal year 1982 to $6.6 million in fiscal year 1987.

Kansas: 73,000 employees. Costs: from $2.9 million to $6.4 million in last five years.

Arkansas: About 50,000 employees. Costs: from $3 million to $6.3 million in the last five years.

Wisconsin: 67,500 employees. Costs: from $2.7 million to $6.2 million in last five years.

Tennessee: 60,000 employees. Costs: from $4.1 million to $5.5 million in last three years.

Alaska: 13,000 employees. Costs: from $4.1 million in fiscal year 1987 to $5.2 million in fiscal year 1988.

Iowa: 40,000 employees. Costs: from $2.4 million to $4.5 million in last five years.

Virginia: 110,000 employees. Costs: from $1.9 million in 1983 to $4 million in 1987.

Kentucky: 64,316, including some volunteer fire and ambulance employees. Costs: from $2.6 million in 1984 to $3 million in 1987.

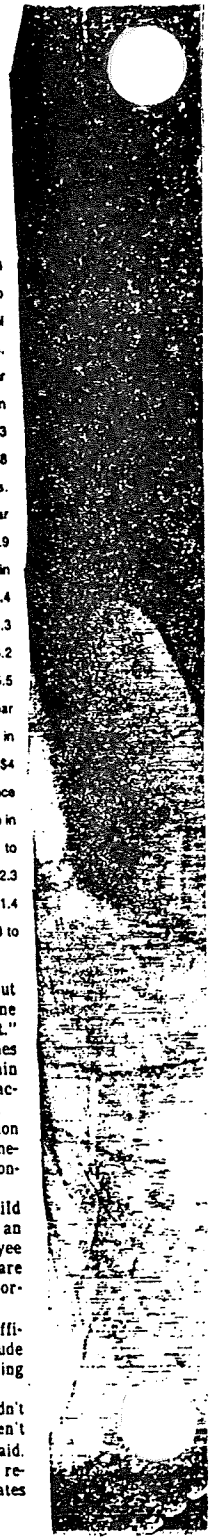
Idaho: 10,000 employees. Costs: from $2.1 million to $2.9 million in the last four years.

New Hampshire: 13,000 employees. Costs: from $1.6 million to $2.7 million in last five years.

Nebraska: 27,000 employees. Costs: from $1.7 million to $2.3 million in last three years.

Utah: 10,500 employees. Costs: from $700,000 in 1983 to $1.4 million 1987.

South Dakota: 13,800 employees. Costs: from $538,000 in 1983 to $956,031 in 1988.



Attachment #8

Kans Business Journal

$1 single copy

VOLUME 7, NUMBER 18 PUBLISHED EVERY WEEK WEEK OF JANUARY 16, 1989

Blue Cross holds fee increase; evalutes jump in doctor fees

BY BRENT SCHONDELMEYER

Blue Cross and Blue Shield of Kansas City will "hold" any increases in fees for nearly 3,000 participating doctors until it can determine why 1988 fees rose faster than any place in the country.

Physician fees paid by the area's largest health insurer — Blue Cross and Blue Shield has nearly 400,000 subscribers in 32 counties — increased by 10 percent per physician compared to a 6.5 percent fee adjustment approved Jan. 1, 1988.

The sharper-than-expected increase in physician fees billed to Blue Cross and Blue Shield of Kansas City helped contribute to the overall $25 million loss the plan expects for 1988. No exact dollar amount could be placed on the impact of the higher physician fees.

The 10 percent increase in fees charged to Blue Cross and Blue Shield of Kansas City by physicians is significantly higher than the 6 to 7 percent average increases experienced by other Blue Cross/Blue Shield plans nationwide, according to Richard Krecker, president and chief executive officer of Blue Cross and Blue Shield of Kansas City.

"There's no evidence in morbidity or mortality that people in Kansas City are that much sicker to account for a three percent (difference)," he said.

The rate of increase also is higher than medical economic trends for the area and the nation.

Physicians	1984	1985	1986	1987	1988 (*)
Costs Per Patient	$271	$313	$348	$416	$451
Difference	N/A	$42	$35	$68	$35
Annual % Change	N/A	15.5%	11.2%	19.5%	8.4%

Hospitals	1984	1985	1986	1987	1988
Charge Per Stay	$3,530	$3,828	$4,308	$4,774	$5,082
Difference	N/A	$298	$480	$466	$308
Annual % Change	N/A	8.4%	12.5%	10.8%	6.5%

(*) First Six Months Source: Blue Cross and Blue Shield of KC

The cost of medical care services — physicians, dental and eye care — increased 4.9 percent in the Kansas City area from 1987 to 1988, according to the U.S. Bureau of Labor Statistics.

The average increase for physician services in all U.S. cities was 7.3 percent for the 12-month period ending November 1988.

But Blue Cross and Blue Shield is far from alone in seeing an increase in doctors' fees. Dr. Jeffrey Ackerman with CIGNA Healthplan of Kansas City said

Please turn to page 26

Insurer hopes analysis explains higher costs

Continued from page 1

that plan also had seen an increase of about 10 percent in physicians' fees.

Physicians will continue to be paid based on the 1988 fee schedule until Blue Cross and Blue Shield of Kansas City adopts a new schedule, which could come within a few months.

"We're obliged to review (physician fees) annually, but we're not obliged to act immediately," said Krecker. Physician fees typically have been adjusted about every 14 months and have averaged 5 to 7 percent, he said.

The hold does not affect physicians in Blue Cross and Blue Shield's two health maintenance organizations — Total Health Care and Blue-Care — because they are paid a fixed amount for patients under their care.

The average Blue Cross and Blue Shield physician payout in 1987 was $10,964, but increased to $12,109 for 1988, according to officials.

"The statistics clearly show that physician fees and incomes have gone up higher, but the people who quote these should know that expenses have gone up higher," said Dr. Carl Strauss, chairman of the Peer Review Oversight Committee for the Metropolitan Medical Society of Greater Kansas City.

While a few physicians are making a bundle in the current marketplace, Strauss said primary-care physicians are not.

The Blue Cross analysis will consider, among other things, whether to adjust the weighting factors used to set specialty fees.

Krecker said the 6.5 percent 1988 adjustment was intended as a "reasonable inflation-based fee schedule." He said the additional amounts paid to physicians would not be recouped by paybacks or offset in 1989 rate adjustments.

Physicians	1984	1985	1986	1987
Premiums Earned	$78,559	$84,863	$98,940	$110,927
Claims Incurred	$62,129	$69,138	$82,585	$98,404
% of Premium	79.1%	81.5%	83.5%	88.7%
Expenses Incurred	$11,335	$13,665	$14,444	$17,783
% of Premium	14.4%	16.1%	14.6%	16.0%
Underwriting Gain	$5,093	$2,059	$1,910	($5,260)
% of Premium	93.5%	97.6%	98.1%	104.7%

Hospitals	1984	1985	1986	1987
Premiums Earned	$137,078	$138,674	$151,041	$160,607
Claims Incurred	$122,116	$124,860	$137,765	$152,088
% of Premium	89.1%	90.0%	91.2%	94.7%
Expenses Incurred	$7,347	$10,012	$10,855	$12,935
% of Premium	5.4%	7.2%	7.2%	8.1%
Underwriting Gain	$7,614	$3,802	$2,420	($4,416)
% of Premium	94.5%	97.2%	98.4%	102.8%

(000s) omitted — Source: Kansas Insurance Department

Physician fees account for 38 percent of total benefits paid by Blue Cross and Blue Shield of Kansas City. Hospitals account for 53 percent of the total benefits, with drugs and other costs absorbing the other 9 percent.

"We don't know the economic factors that drive" the increases in physician fees, said Krecker. He added: "The incidence of medical conditions is not that much higher in 1988 compared to 1987."

The preliminary Blue Cross and Blue Shield analysis indicates fee increases were attributable to billing practices which include upcoding, fee fragmentation and overuse of services.

Medical procedures are assigned a computer code which determines how much the third-party payor reimburses the provider for the submitted claim.

Upcoding involves billing a medical service under a procedure category which pays more. Fee fragmentation involves taking a single procedure and billing it as a multiple procedure, such as a followup visit after surgery. Overuse involves medically unnecessary procedures which then are billed to the insurer.

Blue Cross and Blue Shield is not sure what accounts for the discrepancies in the billing practices and hopes its analysis will help it determine the cause. That analysis will look at overall trends and not focus on individual physicians.

"I see isolated cases where they're confused what the code is," said Philip Beard, a manager with Baird Kurtz & Dobson who works with many Kansas City-area physician practices. "I don't know anybody doing it, knowing what the risk is."

Medicare, another major third-party payor, routinely screens physician claims for upcoding or fee fragmentation. Incorrect billing can result in significant financial penalties for the physician.

However, Strauss says that physicians increasingly have been "unbundling" services and charging for procedures which previously had been done at no charge and billed as one service.

"Patients in the past were used to extra things being thrown in," said Strauss. "Now (the physician) watches every penny and every minute of time."

He added: "It's now beginning to pick

Continued on next page

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Continued from preceding page

up speed, so that it has everybody's attention."

The sharp increase in physician fees underscores a larger problem for the financially-pressed insurance plan: Controlling hospital charges has proven easier than fees charged by physicians.

During recent years, the annual percentage change for physician costs per member has easily outstripped the increases in charges per hospital stay (See chart and illustration, page 1).

Up until 1982, there were separate plans for each. Blue Cross of Kansas City covered hospitals while Blue Shield of Kansas City paid physician claims. The merger resulted in both boards combining, sharing assets and operational expenses.

The underwriting of the physician portion of the plan has worsened in recent years. Annual statements, filed with the Kansas Insurance Department, show that physician claims incurred, as a percent of premiums earned, have increased steadily. In 1984, physician claims incurred were 79.1 percent of premiums earned but had climbed to 88.7 percent by 1987 (See table, page 26).

Once administrative expenses were added in, Blue Cross and Blue Shield lost $5.2 million on physician underwriting during 1987. The books for 1988 have not been closed yet.

Among ways to improve the underwriting ratios: increase premiums, reduce claims and expenses or a combination of those.

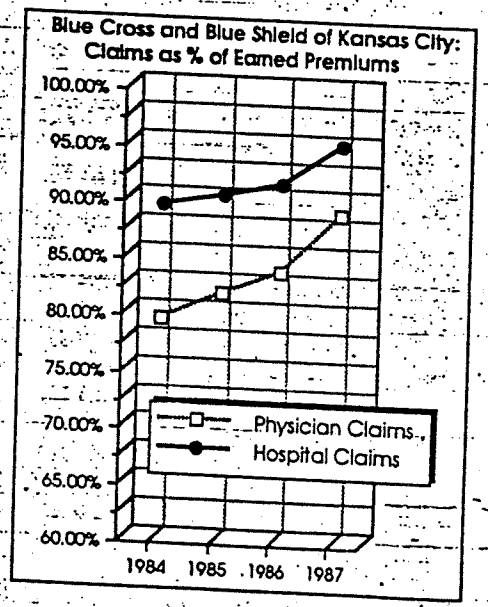
Blue Cross and Blue Shield recently hired Dr. William Bradshaw as vice-president of medical affairs. The former dean of the School of Medicine at the University of Missouri-Columbia was, until recently, president of the Missouri Patient Care Review Foundation, which is a peer review organization that determines whether Medicare claims submitted by providers should be paid.

Blue Cross and Blue Shield, in a letter to participating physicians explaining the fee hold, said "sound medical judgment and quality patient care is totally consonant with fair and equitable business procedures."

The answers, to Beard's mind, are not simple: "I certainly, in their position, wouldn't go ahead and update until I knew what had happened last year and what I wanted to happen this year."

Strauss believes that patients, ultimately, bear some responsibility for rising physician fees and must be willing to pay for the care they expect.

"The solution is not only the doctor," he said. "The solution is going to be partly the patient who doesn't run to the doctor every time he has a sore throat or a hurt toe."



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State Self-Insured Fund
(State employees)

	1984	1985	1986	1987	1988
Disability	1,462,435	1,757,426	2,307,906	2,616,108	3,339,984
Medical	1,447,813	1,344,492	2,096,788	2,163,847	2,853,375
Total	2,910,248	3,101,918	4,404,694	4,779,955	6,193,359
Medical cost changes:		-7.6	155%	103%	131%
Medical as % of total	49.7	43.3	47.6	45.2	46.0

MEDICAL BENEFITS AND FEE SCHEDULES

Jurisdiction	Full Benefits In Law	Law Authorizes Extension Without Limit	Fee Schedules(1)
Alabama	Yes		
Alaska	No	Yes	authorized
Arizona	Yes		rel. value
Arkansas	No	Yes	authorized
California	Yes		rel. value
Colorado (2)	No	Yes	rel. value
Connecticut	Yes		DRG
Delaware	Yes		
Dist. of Columbia	Yes		
Florida	Yes		max.
Georgia	No	Yes	
Hawaii	Yes		max.
Idaho	Yes		
Illinois	Yes		
Indiana	Yes		
Iowa	Yes		
Kansas	Yes		
Kentucky	Yes		authorized
Louisiana	Yes		authorized
Maine	Yes		authorized
Maryland	Yes		rel. value
Massachusetts	Yes		medicaid
Michigan	Yes		max.
Minnesota	Yes		max. percentile
Mississippi	Yes		authorized
Missouri	Yes		
Montana	Yes		rel. value
Nebraska	Yes		rel. value
Nevada	Yes		rel. value
New Hampshire	Yes		
New Jersey	Yes		DRG
New Mexico	Yes		
New York	Yes		max. & DRG
North Carolina	Yes		rel. value & max.
North Dakota	Yes		
Ohio (3)	Yes		
Oklahoma	Yes		authorized
Oregon (3)	Yes		max. percentile
Pennsylvania	Yes		
Rhode Island	Yes		medicare
South Carolina	Yes		max.
South Dakota	Yes		
Tennessee	Yes		
Texas	Yes		rel. value
Utah	Yes		rel. value
Vermont	Yes		
Virginia	Yes		
Washington	Yes		rel. value
West Virginia	Yes		authorized
Wisconsin	Yes		
Wyoming	Yes		rel. value
Longshoremen	Yes		

(1) States which have legislatively authorized. Some may not have adopted as yet.

(2) Colorado: There is a $20,000 maximum on both W.C. and O.D. medical benefits; however, there is a Major Medical Insurance Fund Act which defrays all medical, hospital, surgical, nursing, and drug expenses in excess of the $20,000 limit.

(3) The Ohio and Oregon laws set no initial amount or period; all medical benefits authorized by the administrative agency. In Ohio, in silicosis cases, no medical benefits payable except in cases of total disability or a change of occupation.

No. 54,815
and
No. 54,816
(Consolidated)

MERL EDWARD JOHNSTON, *Claimant-Appellee,* and DONNA PRUYN, *Claimant-Appellee,* v. TONY'S PIZZA SERVICE, d/b/a SCHWAN'S SALES OF MARSHALL, INC., *Respondent-Appellee,* and LIBERTY MUTUAL INSURANCE COMPANY, *Insurance Carrier-Appellee,* and KANSAS WORKMEN'S COMPENSATION FUND, *Appellant.*

(658 P.2d 1047)

SYLLABUS BY THE COURT

WORKERS' COMPENSATION—*Reimbursement for Excess Payment of Compensation.* Where a workers' compensation award is reduced or totally disallowed by a district or appellate court, K.S.A. 1982 Supp. 44-556(*d*) provides the sole means by which the employer and its insurance carrier may be reimbursed for any excess payment of compensation. Said statute provides that such reimbursement shall be from the Workers' Compensation Fund upon certification of the amount by the Director of Workers' Compensation and is not limited in application to reimbursement of overpayment which exceeds the balance due claimant on the award as modified.

Appeal from Saline district court; DAVID S. KNUDSON, judge. Opinion filed February 19, 1983. Affirmed.

John M. Ostrowski, of McCullough, Wareheim & LaBunker, of Topeka, argued the cause and was on the brief for claimant-appellees.

C. Stanley Nelson, of Hampton, Royce, Engleman & Nelson, of Salina, argued the cause and was on the brief for appellant.

Aubrey G. Linville, of Clark, Mize & Linville, Chartered, of Salina, was on the brief for respondent-appellee and insurance carrier-appellee.

The opinion of the court was delivered by

McFARLAND, J.: The sole issue in these consolidated workers' compensation appeals is whether the reimbursement provision of K.S.A. 1982 Supp. 44-556(*d*) applies when the balance due the claimant after judicial reduction of the award exceeds the amount of the overpayment.

K.S.A. 1982 Supp. 44-556(*d*) provides:

"(*d*) If compensation has been paid to the worker by the employer or the employer's insurance carrier during the pendency of an appeal to the district court or to the appellate courts and the amount of compensation awarded by the director or the district court is reduced or totally disallowed by the decision on the appeal, the employer and the employer's insurance carrier, except as otherwise provided in this section, shall be reimbursed from the workers' compensation fund established in K.S.A. 44-566a and amendments thereto for all amounts of compensation so paid which are in excess of the amount of compensation that the worker is entitled to as determined by the final decision on appeal. The

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director shall determine the amount of compensation paid by the employer or insurance carrier which is to be reimbursed under this subsection, and the director shall certify to the commissioner of insurance the amount so determined. Upon receipt of such certification, the commissioner of insurance shall cause payment to be made to the employer or the employer's insurance carrier in accordance therewith."

It should be noted that K.S.A. 44-556(*d*) was amended by the 1982 Legislature effective after the date of certification herein. However, these amendments relate wholly to form rather than substance. Accordingly, this opinion will refer only to the statute as amended.

The issue in both appeals is as previously noted, identical. Each claimant is in a factually similar situation as far as the issue is concerned. The stipulated facts from the Johnston appeal are summarized as follows:

On February 1, 1982 the Workers' Compensation Director found claimant had a 50% permanent partial disability to the body as a whole and fixed compensation at $77.88 per week for 400.71 weeks. Respondent and the insurance carrier appealed this award to the district court. The court found claimant had only a 30% permanent partial disability to the body as a whole. Accordingly, the award was reduced to $46.72 per week for 400.71 weeks of which $15,381.62 would be due and owing in the future.

For the ten-week period prior to the Director's decision and for the period said award was on appeal to the district court, respondent and its insurance carrier, pursuant to K.S.A. 1982 Supp. 44-556, paid a total of 20.71 weeks of compensation at the 50% disability rate of $77.88. Deducting the 30% disability rate of $46.72 therefrom results in a $31.16 per week overpayment for 20.71 weeks for a total of $645.32.

Respondent and its insurance carrier then made request to the Director, pursuant to K.S.A. 1982 Supp. 44-556(*d*) to certify said $645.32 overpayment to the Commissioner of Insurance for reimbursement by the Kansas Workers' Compensation Fund. The Director issued said order of certification, and the Fund appealed therefrom to the district court. The order of certification was affirmed by the district court and the Fund appeals from said judgment.

Obviously, resolution of the issue herein involves statutory construction and the general applicable rules need to be stated.

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The first rule of statutory construction is to ascertain, if possible, the intent of the legislature. *Nordstrom v. City of Topeka,* 228 Kan. 336, 340, 613 P.2d 1371 (1980), *Brinkmeyer v. City of Wichita,* 223 Kan. 393, Syl. ¶ 2, 573 P.2d 1044 (1978). Consistent with the first rule, it is fundamental the purpose and intent of the legislature governs when that intent can be ascertained from the statute. *Kansas State Board of Healing Arts v. Dickerson,* 229 Kan. 627, 630, 629 P.2d 187 (1981). Finally, where a statute is plain and unambiguous, Kansas courts must give effect to the intention of the legislature as expressed rather than determine what the law should or should not be. *Johnson v. McArthur,* 226 Kan. 128, 596 P.2d 148 (1979); *Brinkmeyer v. City of Wichita,* 223 Kan. at 397. All parties to this action agree K.S.A. 1982 Supp. 44-556(*d*) is unambiguous.

The crux of the issue is the import of the following emphasized portion of K.S.A. 1982 Supp. 44-556(*d*):

"[T]he employer and the employer's insurance carrier . . . shall be reimbursed from the workers' compensation fund . . . for all amounts of compensation so paid *which are in excess of the amount of compensation that the worker is entitled to as determined by the final decision on appeal.*" (Emphasis supplied.)

The Fund contends that the emphasized language limits reimbursement from the Fund to those situations where the total amount of overpayments exceeds the total amount of compensation remaining to be paid. Future payments to claimant Johnston totalled $15,381.62, while the overpayments totalled only $645.32. The Fund then concludes that the statute does not impose liability on the Fund for the reimbursements herein and that the remedy of the employer and its insurance carrier is to make themselves whole by withholding funds from future payments to claimant.

The fallacy of this argument is pointed out by the claimant. There is no procedure or authorization which permits deducting the overpayment from future payments due the claimant. If all payments were withheld by the insurance carrier until it had reimbursed itself for its overpayment to claimant Johnston, the injured worker would go 12 consecutive weeks without any workers' compensation being received. Claimant Donna Pruyn's award of $77.28 a week was reduced by the district court to $12.88 per week for 387.13 weeks with the total overpayment

being $1,159.20. Therefore, 81 weeks would have to elapse before Ms. Pruyn could receive another check if this method of reimbursement were utilized. Did the Legislature intend to leave it to the employer and insurance carrier to decide whether to repay themselves immediately, at the end of the payment period, or by deduction of a percentage each week? Such an intent would be highly unlikely and out of keeping with the philosophy of workers' compensation.

The Fund has not shown us any instance in the history of the Kansas Workmen's Compensation Act, K.S.A. 44-501 *et seq.*, where the Legislature has required an injured worker to repay an employer or its insurance carrier when an award has been reduced on judicial appeal. In fact, our case law has indicated the opposite legislative intent. See *Casebeer v. Alliance Mutual Casualty Co.*, 203 Kan. 425, 454 P.2d 511 (1969); and *Tompkins v. Rinner Construction Co.*, 196 Kan. 244, 409 P.2d 1001 (1966).

The Fund cites *Streff v. Goodyear Tire & Rubber Co.*, 211 Kan. 898, 508 P.2d 495 (1973), in support of its argument that the insurance carrier can set off the overpayments against future payments due claimant. This reliance is misplaced. *Streff* involved a $1,100 lump-sum payment by the insurance carrier in a nonstatutorily authorized attempt at settlement of the claim. The settlement did not occur and the claim went through to hearing and award. On appeal before this court, the question was raised as to whether credit should be allowed for this irregular voluntary predecision payment. The court held:

"To disallow the respondent and its insurance carrier a credit for the subject payment would work an obvious inequity. It must be conceded the Kansas Workmen's Compensation Laws are to be liberally construed so as to allow payment of compensation whenever reasonably possible. This is not to say, however, that an injured workman should be allowed to receive what would amount to double payment in a situation such as here.

". . . The allowance of a credit or set-off for the $1,100 payment would in no way affect the claimant's statutory rights. To disallow the credit would be contrary to the principles of equity." 211 Kan. at 903-04.

The *Streff* "situation such as here" is obviously wholly dissimilar to the situation before us involving overpayments pursuant to awards which were later judicially reduced. Additionally, *Streff* was decided prior to the enactment of 44-556(*d*) and was decided on general equity principles.

Much of the Fund's brief herein is devoted to the policy

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argument that the claimant should not receive a windfall to which he or she is not entitled except when he or she would have to dig into his or her own pocket to repay the overpayment. The policy argument loses considerable impact when applied to the facts before us—that is, it would be an unfair burden if Ms. Pruyn had to pay the $1,159.20 overpayment from her pocket, but only right and fair if she has 81 consecutive weeks of compensation totally withheld to repay the insurance carrier. In any event, as pointed out by the claimant, the policy argument would be better addressed to the Legislature as its implementation would entail substantial statutory modification.

We conclude that where a workers' compensation award is reduced or totally disallowed by a district or appellate court, K.S.A. 1982 Supp. 44-556(*d*) provides the sole means by which the employer and its insurance carrier may be reimbursed for any excess payment of compensation. Said statute provides that such reimbursement shall be from the Workers' Compensation Fund upon certification of the amount by the Director of Workers' Compensation and is not limited in application to reimbursement of overpayment which exceeds the balance due claimant on the award as modified.

This result is consistent with the comments of the five Kansas law journal authors who discussed the effect of 44-556(*d*) shortly after its enactment—including an article written by Bryce B. Moore, Workers' Compensation Director. Moore, *Workmen's Compensation—An Introduction to Changes in the Kansas Statute*, 24 Kan. L. Rev. 603, 608 (1976); Herrington, *Workmen's Compensation—Major Changes in Employments Covered, Benefits, Defenses, Offsets, and Other Changes*, 24 Kan. L. Rev. 611, 616 (1976); Ross, *Workmen's Compensation—The Preliminary Hearing, The Workmen's Compensation Fund, and Civil Penalties for Failure to Pay Compensation When Due*, 24 Kan. L. Rev. 623, 625 (1976); Wright & Rankin, *Potential Federalization of State Workmen's Compensation Laws—The Kansas Response*, 15 Washburn L.J. 244, 258, n. 73 (1976).

We further conclude, on the rationale hereinbefore expressed, that the trial court did not err in affirming, in both cases herein, the Workers' Compensation Director's orders of certification to the Commissioner of Insurance for payment from the Workers' Compensation Fund.

The judgment in each of the consolidated cases is affirmed.

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"WHERE DO I GO IF I'M INJURED ON THE JOB?"

If you are injured on the job, report to St. Francis Emergency Room at 1700 S.W. 7th Street.

No hassels, no forms. The State has contracted with St. Francis to provide you with all the medical care you need to get you back to work.

Any services provided by anyone other than St. Francis, or their referrals, will be limited to $350.00 as "unauthorized medical".

If you are currently receiving Worker's Compensation medical payments, continue to see the physician you are currently seeing for the accident or injury.

For more information on the process, and your rights as State employees, see your agency Personnel Officer.

Office of Risk Management
Division of Personnel Services

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 Bank IV Tower One Townsite Plaza Topeka, KS 66603-3460 (913) 357-6321

A consolidation of the Kansas State Chamber of Commerce, Associated Industries of Kansas, Kansas Retail Council

Sub. for HB 3069 April 2, 1990

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Labor, Industry and Small Business

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Madam Chairperson and members of the Committee:

I am Terry Leatherman, with the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to urge the Committee's support for Substitute for HB 3069, as originally proposed.

At the heart of Substitute for HB 3069 is the creation of a medical fee schedule and utilization review program for the Kansas workers' compensation system. Workers' compensation, like all other forms of health care insurance, is experiencing skyrocketing premium increases. There are several reasons why cost containment methods are needed in the Kansas workers' compensation system.

1. The Kansas Insurance Commissioner is currently considering a 22.6% average increase in workers' compensation insurance rates in Kansas. If approved, many Kansas employers will face a 50% increase in their workers' compensation insurance premiums.

2. Medical costs currently total nearly 50% of the benefits paid in the

Attachment I
4-2-90

te's workers' compensation system. According to the National Counc on Compensation Insurance, medical costs are 30% to 40% of total claims paid in most states.

3. Attempts by private workers' compensation insurance companies to perform medical cost control have been flawed. The biggest problem is all cost containment is after the medical care is provided and payment is expected. As a result, the only way to resolve disputes is through litigation, which sparks an adversarial between all parties. In addition, the fragmented workers' compensation insurance market in Kansas makes developing the proper data base to perform cost containment very difficult.

4. Current Kansas law gives the Workers' Compensation Director the authority to create a medical fee schedule and utilization review process. However, additional legislation is needed to insure the system will be fair to all parties and continued by future Directors of the department.

In short, workers' compensation costs are soaring, and increases can be traced to the high cost of medical care. Substitute for HB 3069 addresses these problems in a way which would benefit all participants in the process.

EMPLOYERS-Passage of Substitute for HB 3069 should significantly reduce medical costs in workers' compensation. The National Council for Compensation Insurance suggests the institution of a medical fee schedule will reduce costs 12%. In Kansas, a conservative savings estimate would be $15 million.

EMPLOYEES-The major concern over adoption of cost control measures for the employee centers on whether the quality of medical care would be altered. That will not happen if the medical fee schedule mirrors schedules by private insurance carriers, such as Blue Cross/Blue Shield. The integrity of the schedule will be assured by the Medical Fee Advisory Panel.

LTH CARE PROVIDERS-The Advisory Panel, which would assist the direc... in the annual review of the medical fee schedule would be well-represented by members of the medical community, who will insist the fee schedule be reasonable. Because there will be a greater understanding of what medical fees should be charged, there should be less disputes over fees and bills should be paid more promptly. If a dispute should arise in medical service utilization, the peer review panel will judge a doctor's performance from a medical perspective.

LEGAL SYSTEM-The fee schedule and utilization/peer review should simplify medical charge disputes within the workers' compensation system. When disputes do require judicial review, the introduction of impartial medical opinions should bring more fairness to the judicial decision making process.

While the medical fee schedule and utilization review system are at the heart of Substitute for HB 3069, there are other important refinements to the state's workers' compensation system in this legislation.

* (page 13) Protection for the injured worker who has been released to return to work with medical restrictions, from losing temporary total disability comensation, if the worker still cannot perform on the job.
* (page 21) An increase in the civil penalty for failing to pay medical charges, which should encourage prompt payment of medical bills to health care providers.
* (page 26) Elimination of a requirement for a claimant to show 'unusual circumstances before receiving temporary total disability payments, prior to the filing of an application for the payments.
* (page 27) Time restrictions on rulings from the Workers' Compensation Director, which should accelerate the system's litigation process.
* (page 30) Allowing the employer to receive a credit for over-payments made to an injured workers, which would be subtracted from remaining

/ments, following a district court ruling.

While KCCI endorses all of the provisions in this compromise legislation, we urge this Committee to remove additions made to the bill by the Kansas House of Representatives. The additions which KCCI would like to see removed are shown on the next three pages, following my testimony.

Of the three House amendments to the bill, the one KCCI finds most objectionable is granting the right of first choice of physician to the employee. Workers' compensation is a state mandated program where employers pay to insure their employees are cared for, if they suffer a workplace injury. Employees make no contributions to premiums, pay no deductible charges, or pay any money for medical care provided. Since the state requires employers to pay all costs for this system which benefits employees, it seems only fair to arm the employer with all the cost saving tools possible, as long as the care for the injured worker is not affected. The most effective cost reduction tool, according to the N.C.C.I., is choice of physician. The second most effective tool is a medical fee schedule and utilization review system. To remove employer choice of physician disarms the employer in the effort to control the cost of workers' compensation, and would make passage of Substitute for HB 3069 counter-productive.

Thank you for the opportunity to express the Kansas Chamber's support for this legislation. I would be happy to attempt to answer any questions.

(1) The director shall prepare and adopt rules and regulations which establish a schedule for the state approved by the advisory panel, or schedules approved by the advisory panel which are limited to defined localities, fixing the maximum fees for medical, surgical, hospital, dental, nursing, vocational rehabilitation or any other treatment or services provided or ordered by health care providers and rendered to employees under this section. Each such schedule shall include provisions and review procedures for exceptional cases involving extraordinary medical procedures or circumstances and shall include costs and charges for medical records and testimony.

(2) The schedules of maximum fees shall be reasonable, shall promote health care cost containment and efficiency with respect to the workers compensation health care delivery system, and shall be sufficient to ensure availability of such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury.

(3) (A) In every case, all fees, transportation costs and charges under this section and all costs and charges for medical records and testimony shall be subject to approval by the director and shall be limited to such as are fair, reasonable and necessary.

(B) There is hereby created an advisory panel to assist the director in establishing schedules of maximum fees as required by this section. The panel shall consist of the commissioner of insurance and six members appointed as follows: (i) One person shall be appointed by the Kansas medical society, (ii) one member shall be appointed by the Kansas association of osteopathic medicine, (iii) one member shall be appointed by the Kansas hospital association, (iv) one member shall be appointed by the Kansas chiropractic association, and (v) two members appointed by the secretary. One member appointed by the secretary shall be a representative of employers recommended to the secretary, ~~for the initial term of office commencing July 1, 1990, and for each term of office commencing at the end of each four-year period thereafter, by the Kansas chapter of the national federal of independent business and a representative recommended to the secretary, for the term of office commencing July 1, 1992, and for each term of office commencing at the end of each four-year period thereafter~~, by the Kansas chamber of commerce and industry, ~~so that recommendations are made to the secretary for the representative of employers on an alternating basis by such organizations~~. The other member appointed by the secretary shall be a representative of employees recommended to the secretary by the Kansas AFL-CIO. Each appointed member shall be appointed for a term of office of two years which shall commence on July 1 of the

year of appointment. ~~Appointments to the advisory panel shall be made in such a manner that the gender of members is representative of residents of the state and the appointing authorities~~ shall ~~consult each other to accomplish that end.~~

(C) The panel shall annually review and approve the schedules of maximum fees for such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury. All fees and other charges paid for such treatment, care and attendance, including treatment, care and attendance provided by any health care provider, hospital or other entity providing health care services, shall not exceed the amounts prescribed by the schedules of maximum fees established under this section or the amounts authorized pursuant to the provisions and review procedures prescribed by the schedules for exceptional cases. A health care provider, hospital or other entity providing health care services shall be paid either such health care provider, hospital or other entity's usual charge for the treatment, care and attendance or the maximum fees as set forth in the applicable schedule, whichever is less. In reviewing and approving the schedules of maximum fees, the panel shall consider the following:

(i) The levels of fees for similar treatment, care and attendance imposed by other health care programs or third-party payors in the locality in which such treatment or services are rendered;

(ii) The impact upon cost to employers for providing a level of fees for treatment, care and attendance which will ensure the availability of treatment, care and attendance required for injured employees;

(iii) The potential change in workers compensation insurance premiums or costs attributable to the level of treatment, care and attendance provided; and

(iv) The financial impact of the schedule of maximum fees upon health care providers and health care facilities and its effect upon their ability to make available to employees such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury.

(D) Members of the advisory panel attending meetings of the advisory panel, or attending a subcommittee of the advisory panel authorized by the advisory panel, shall be paid compensation, subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3223 and amendments thereto.

(4) Any contract or any billing or charge which any health care provider, hospital, person, or institution enters into with or makes to any patient for services rendered in connection with injuries cov-

approved by the director and no injured employee or dependent of a deceased employee shall be liable for any charges above the amounts approved by the director. If the employer has knowledge of the injury and refuses or neglects to reasonably provide the benefits required by this section, the employee may provide the same for such employee, and the employer shall be liable for such expenses subject to the regulations adopted by the director. ~~Injured workers shall have the right in the first instance, to select a health care provider. Either party can request changes in the health care provider pursuant to a preliminary hearing before an award or subsection (a) of K.S.A. 44-536 and amendments thereto after final award or judgment.~~ No ~~judgment may be entered by any district court in any~~ action *shall be filed in any court by a health care provider or other provider of services under this section* for the payment of an amount for medical services or materials provided under the workers compensation act and ~~such action shall be stayed~~ *no other action to obtain or attempt to obtain or collect such payment shall be taken by a health care provider or other provider of services under this section, including employing any collection service,* until *after* final adjudication of any claim for compensation for which an application for hearing is filed with the director under K.S.A. 44-534 and amendments thereto. *In the case of any such action filed in a court prior to the date an application is filed under K.S.A. 44-534 and amendments thereto, no judgment may be entered in any such cause and the action shall be stayed until after the final adjudication of the claim.* In the case of an action stayed hereunder, any award of compensation shall require any amounts payable for medical services or materials to be paid directly to the provider thereof plus an amount of interest at the rate provided by statute for judgments. *No period of time under any statute of limitation, which applies to a cause of action barred under this subsection, shall commence or continue to run until final adjudication of the claim under the workers compensation act.*

(c) If the services of the ~~physician~~ *health care provider* furnished as provided in subsection (a) are not satisfactory to the injured employee, the director may authorize the appointment of some other ~~physician~~ *health care provider* subject to the limitations set forth in this section and the rules and regulations adopted by the director. Without application or approval, an employee may consult a ~~physician~~ *health care provider* of the employee's choice for the purpose of examination, diagnosis or treatment, but the employer shall only be liable for the fees and charges of such ~~physician~~ *health care provider* up to a total amount of $350.

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