Approved March 16 1992
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~xxx~~ a.m./p.m. on March 5, 1992 in room 531 N of the Capitol.

All members were present except:

Representative Sebelius - Excused

Committee staff present:

Mr. Fred Carman, Revisor
Mr. Chris Courtwright, Research
Mrs. Emalene Correll, Research
Mrs. Nikki Feuerborn, Secretary

Conferees appearing before the committee:

Mr. Jim Schwartz, Kansas Employer Coalition on Health
Mr. David Hanzlick, Kansas Dental Association
Ms. Melissa Hungerford, Kansas Hospital Association
Mr. John Noonan, AARP
Mr. Richard Morrissey, Information Services of Health & Environment
Mr. Lyndon Drew, Department of Aging
Mr. Bill Sneed, HAIA and State Farm
Representative Douville
Mr. David Hills, Attorney
Mr. David Hanson, Property and Casualty Insurance

**Hearing on HB 2585 - Kansas medical database act.**

Mrs. Emalene Correll of the Research Department gave a staff review of the bill. The purposes of the Act, as stated, are to obtain an understanding of patterns and trends in the use and cost of medical services. The bill will require all medical care facilities to supply information necessary for review and comparison. The information is to be compiled and made available to medical care providers, payors, medical care consumers and health care planners to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of appropriate medical care services.

The bill also provides that the Insurance Commissioner is to administer the database. The responsibilities include provisions that the Insurance Department identify and compile a list of those medical facilities which must report data under the Act, adopt rules and regulations needed to collect and disseminate the data, answer inquiries and provide additional information beyond routine data disseminated, coordinate and permit providers the opportunity to verify the accuracy of their own data, and advise medical care facilities of the precise data to be provided for inclusion in the database. The Insurance Commissioner will be also be required to prepare an annual report regarding the database.

Mr. Jim Schwartz, Director of the Kansas Employer Coalition on Health, Inc., appeared before the committee as a proponent. With comparative data which would be available through this database, purchasers can make informed decisions about patronizing providers and the need for such providers. A list of suggested amendments and changes to the bill was included. (See Attachment 1).

Mr. David Hanzlick of the Kansas Dental Association, appeared as an opponent of **HB 2528.** Requiring direct reporting by providers would not be efficient or cost effective. Rather, it would increase the paperwork burden that already plagues health care and add to the cost problem. The Kansas Dental Association also believes that license revocation as the penalty for non-compliance is overly harsh and unwarranted. (See Attachment 2).

Ms. Melissa Hungerford of the Kansas Hospital Association, spoke as an opponent of the bill. Currently a number of public and private organizations collect and disseminate health care information. These include the Kansas Hospital Association, the American Hospital Association, Kansas Department of Health and Environment, Health Care Financing Administration, and SRS. The issue is whether there is a need for such collection. (See Attachment 3).

Mr. John Noonan, American Association of Retired Persons, appeared as an opponent of the bill. The need for such a health care data system is recognized. The organization believes the center should be established in the Department of Health and Environment rather than under the auspices of the Insurance Commissioner. The bill does not include groups outside the Department of Insurance who would be deeply involved in the process and whose advice and cooperation would be essential for a productive effort. Also the bill focuses primarily on on costs associated with medical care facilities. (See Attachment 4).

**Hearing on HB 2186 - Establishing a health data commission.**

Mrs. Emalene Correll of the Research Department gave the staff review. This bill would provide for the establishment of a Health Data Commission responsible for the acquisition, compilation, analysis and dissemination of data from health care providers and third-party payers. The Commission would be made up of 11 members including members of established commissions, state agencies, elected officials, health professionals, with administrators being named by the Governor. The bill would allow the Commission to enter into agreements with corporations or other entities for the purpose of assisting with the compilation, correlation and development of data collected by the Commission. Funding for the program would be provided through legislative appropriations and through fees assessed on clients seeking access to information collected by the Commission. Information would be collected through state agencies, as well as health care providers. Records collected under the act shall be considered confidential, but data compilations prepared by the Commission would be matters of public record.

Mr. Richard Morrissey, Informational Services of Health and Environment, appeared before the committee to explain the need to establish funding and a process for gathering information prior to the establishment of such a commission. The information currently gathered is related to vital statistics rather than health data.

Mr. John Noonan, representing the AARP, indicated support for this bill.

Mr. Lyndon Drew, Department on Aging, believes that a data collection system which does not duplicate but coordinates existing data collection should be developed in Kansas. The state needs data to plan for adequate health manpower. Current data is no longer available for long term care as a part of the state health plan. Kansas-specific discharge planning data would be useful because there apparently is a wide range of practice between states. The link between hospital and other community services is an essential part of health care delivery. (See Attachment 5).

Mr. David Hanzlick, Kansas Dental Association, spoke on behalf of the bill. The bill would provide a more efficient method of data collection than **HB 2528.** The data would be requested from third party payors who would be better able to provide data in a relatively consistent, reliable, and cost-effective manner. (See Attachment 2).

Mr. Bill Sneed, HAIA, spoke as an opponent to the bill, as it would increase costs for insurance companies. More definitive ideas and procedures must be developed before beginning the project.

MINUTES OF THE House COMMITTEE ON Insurance,

room 531, Statehouse, at 3:30 ~~a.m.~~/p.m. on March 5, 19 92

**Hearing on HB 3107 - Relating to uninsured motorists coverage,**

Mr. Chris Courtwright of the Research Department gave a staff review of the bill. This bill pertains to mandatory uninsured and underinsured motorist coverage in automobile liability insurance policies. New language proposed by the bill would prohibit an uninsured motorist insurer, who has been sued for recovery of a claim, from asserting the defense that other liability coverage exists, without first joining the other liability insurer into the lawsuit as an actual additional party defendant.

Representative Douville introduced the proposed legislation and Mr. David Hills, an attorney of Kansas City who explained the need for the bill. This bill would fully and fairly address the problem of resolving in the principal case at the earliest possible moment a dispute between two insurance carriers, i.e. the uninsured motorist carrier and the alleged liability carrier. (See Attachment 6).

Mr. Bill Sneed, appeared for State Farm as an opponent of the bill. The current system is now working fine and there is no reason to change it.

Mr. David Hanson, Property and Casualty Insurance, spoke an as opponent to the bill. He reiterated that the current system for establishing responsibility is reliable and that it should not be tampered with.

Mr. Rick Wilborn, Alliance Insurance Companies of McPherson, Kansas, presented written testimony only in opposition to the proposed bill. This will would require the uninsured motorist coverage insurer to bear the burden of pleading and proving the applicability of the coverage of the alleged policy of liability insurance to the claim being made against such insurer under the uninsured motorist coverage. It would add cost to the system and would add to the time it takes to settle and create an adversarial environment between insurer and insured. (See Attachment 7).

Mr. Richard Mason, Kansas Trial Lawyers Association, presented written testimony only in support of the bill. (See Attachment 8).

Representative Cornfield moved to approve the minutes of March 3, 1992. Representative Cozine seconded the motion. Motion carried.

Meeting adjourned at 5:20 p.m.

# GUEST LIST

COMMITTEE: House Insurance DATE: March 5, 1992

| NAME (PLEASE PRINT) | ADDRESS | COMPANY/ORGANIZATIO |
|---|---|---|
| LISA Getz | | Wichita Hospitals |
| Mary Ellen Conlee | Wichita | KS. Assoc for Small Business |
| Steve Jones | Wichita | Boeing |
| Jerry W. Pitman | Topeka | KS Foundation for medical Care |
| Jerry SLAUGHTER | TOPEKA | KS. MEDICAL SOC. |
| LARRY MAGILL | TOPEKA | I.I.A.K. |
| MELISSA HUNSERFORD | TOPEKA | KHA |
| Arthur Douville | OPK | Legislator |
| DAVID HILLS | KCKS | guest |
| Jim Schwartz | Topeka | KCCI |
| Jeff Keenan | Manhattan | AARP SLC |
| JIM OLIVER | TOPEKA | PCAK |
| George Goebel | Topeka | AARP-SLC.-CCTF |
| Roger D KIRKWOOD | TOPEKA | AARP-CCTF |
| David Hanzlik | Topeka | KS Dental Assn |
| Lyndon Drew | Topeka | K. DOA |
| R. D. Frey | " | KTLA |
| Gary Robbins | " | Ks Opt Assn |
| Marty Kennedy | " | Div. of Budget |
| Richard Morrissey | TOPEKA | KDHE |
| Bill Sneed | TOPEKA | HIAA / State Farm |
| Bob Williams | Topeka | Ks. Pharmacists Assoc |
| Brad Smoot | | |
| | | |
| | | |

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

**Testimony to House Insurance Committee on**
**HB 2528**
**(medical database)**

by James P. Schwartz Jr.
Consulting Director
March 5, 1992

The Kansas Employer Coalition on Health is nearly 100 employers across the state who share concerns about the cost of health care purchased for our 350,000 employees and dependents.

When the Coalition was formed in 1983, our number-one priority was to obtain data on health-care prices and utilization. The reason was that buyers of health care had little information on which to base purchasing decisions. We had no way of knowing whether one hospital's charges were preferable to another's. We had no way of knowing whether a hospital kept patients longer than another, or whether one was more accustomed than another to performing a particular procedure. Health care was the only major commodity we bought sight unseen, with a blank check.

The result of that blank check syndrome is painfully clear to us all today. Health-care costs now exceed profits for most companies. The widening gap between wages and cost of living is almost entirely due to health-care inflation.

In 1983 the Coalition made national news as the first business/health coalition to launch a voluntary data project with hospitals (in Topeka). I wish I could report that this voluntary approach was satisfactory. The project died a few years ago when one of the hospitals withdrew its cooperation after we objected to its expansion plans. In Wichita the project languishes because those hospitals refuse to supply price information. In the Kansas City area another coalition has tried unsuccessfully for years to get useful data from hospitals. It seems clear that a purely voluntary approach to medical data is inadequate.

With comparative data, purchasers can make informed decisions about patronizing providers. We could determine which providers conduct enough of a given procedure to remain proficient. We could determine whether to contract directly with particular providers. If data were available, purchasers could more easily form preferred provider organizations (PPOs). Employers could determine whether a PPO's discount is valuable — by knowing what the basis for the discount is.

About half of states have medical databases. Most of them are complex and expensive. In these difficult economic times, we think it prudent to consider only a simple and inexpensive database. Fortunately, the most helpful kinds of data already exist in electronic form. Hospitals routinely capture charge and utilization data as part of their federal requirements. We don't need to reinvent that wheel. That's why HB 2528 provides for an existing state agency to contract with an outside organization for compiling and reporting of statistics. Rather than the millions of dollars commonly appropriated for stand-alone data commissions, HB 2528 authorizes only $100,000.

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In the interest of simplicity and economy, we recommend that HB 2528 be amended somewhat.

On p. 1, for the sentence continuing on line 28, substitute "statistical data on price and utilization of medical services provided in acute care facilities." This modification avoids a popular connotation of the word "aggregate" in the original text, often taken to mean that identities of facilities will not be reported. Likewise, on line 35 substitute the word "statistical" for the word "aggregate."

On lines 30 and 31, substitute for the words "cost, utilization patterns and quality" the following: "charges and utilization patterns". This modification clarifies the nature of the price information and deletes reference to quality information, which is too ambitious and controversial for purposes of this bill.

On p. 2, after the word data, insert "on a facility-by-facility basis" to clarify that the reports are intended to be usable in a comparative fashion.

On line 14, after the word "from," substitute the following: "hospital out-patient departments and free-standing ambulatory surgical facilities." This modification is to confine the scope of the database to providers from whom data is readily available in electronic form.

Delete paragraph (4) starting on line 39. This modification recognizes that statistical reports will find their way into the public domain and that attempts to deny access to such information are futile.

On page 3, strike paragraph (7). This modification avoids reference to long-term-care facilities, for which a database is beyond the scope of this bill.

Besides providing value to purchasers, a medical database would be extremely helpful to planners. The 403 Commission, for example, would be aided by having reliable statistical information. HB 2528 delivers much desirable information at a reasonable cost.

Since the introduction of the bill in the 1991 session, observers have suggested that the proper administrator should be the Secretary of Health and Environment, instead of the Insurance Commissioner as indicated in the bill. This amendment might well be helpful. One reason is that the bill includes analysis of demographic data that would be valuable to that agency's planning efforts.

For all these reasons, short-term and long-term, we strongly support passage of this bill.

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KDA
KANSAS DENTAL ASSOCIATION

Statement by David Hanzlick
House Committee on Insurance
HB 2528 and HB 2186
March 5, 1992

Mr. Chairman and Members of the Committee, my name is David Hanzlick. I am the Assistant Director of the Kansas Dental Association, which represents 80 percent of Kansas dentists. I appreciate the opportunity to share the concerns of the KDA with regard to HB 2528 and HB 2186.

The Kansas Dental Association shares the concern of the bills' authors in regard to the increasing costs of health care services and improving health care policy-making through increased access to information.

The Kansas Dental Association believes that if a medical data base is developed in Kansas, the information should be collected in the most efficient and cost effective manner. For that reason, we oppose the approach taken by HB 2528, which would place the reporting responsibility directly on the providers who submit third party claims.

Requiring direct reporting by providers would not be efficient or cost effective. Rather it would increase the paperwork burden that already plagues health care and add to the cost problem. The Kansas Dental Association also believes that license revocation as the penalty for non-compliance is overly harsh and unwarranted.

If the collection of data is necessary, the approach taken by HB 2186 would provide a more efficient method of data collection. The data would be requested from third party payors who would be better able to provide data in a relatively consistent, reliable, and cost-effective manner.

The Kansas Dental Association is concerned about the type of information that will be collected under Section 3 of the bill, how it will be used and disseminated and whether the data that is released will be identified by the name of the provider. The Committee may also want to strengthen the provisions of that relate to correcting errors that are found in the commissions data.

Thank you for the opportunity to address this issue.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

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KANSAS HOSPITAL ASSOCIATION

Memorandum

**Donald A. Wilson**
President

March 5, 1992

TO: House Insurance Committee

FROM: Kansas Hospital Association

RE: HOUSE BILLS 2186 AND 2528

The Kansas Hospital Association appreciates the opportunity to comment regarding House Bills 2186 and 2528. Both these bills would create a state health data system.

This topic has been discussed by the Kansas Legislature in several different settings. During the 1990 session, Senate Bill 675, which was similar to HB 2186, was introduced. During the interim between the 1990 and 1991 sessions, the Special Committee on Public Health and Welfare Committee examined the issue.

Although we think the topic of collecting, analyzing, disseminating and discussing health care information is timely and appropriate, we feel that in general these two bills put the cart before the horse. The starting point for discussions is not with the creation of a new state agency--it is with an examination of current information and a careful analysis of what else is necessary.

Currently a number of public and private organizations collect and disseminate health care information. For example, the Kansas Hospital Association annually collects data about member hospitals. The American Hospital Association also compiles an annual survey, again collecting basic data about hospital finances, patient utilization and hospital personnel. The Kansas Department of Health and Environment performs another annual hospital survey, collecting various types of data concerning hospitals. The most significant collection effort is performed by the Health Care Financing Administration through the Medicare cost reports that are filed with federal and state fiscal intermediaries and are public information. These reports contain detailed

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1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

financial information about hospitals. They are regularly analyzed and summarized by business groups, state agencies and the news media. The State of Kansas currently requires that hospitals provide a copy of their cost reports to SRS. Finally, insurers and private sector entities which monitor health care costs are increasing the ways they analyze and report hospital data.

It is obvious from the foregoing that there are indeed many sources of data already providing a significant amount of information about health care provider finances and costs. The issue then becomes whether there is a need to create a new state agency at additional cost to gather more information. The solution to this problem cannot come without first considering what purpose this health care information is supposed to serve. Is it supposed to benefit the state, consumers of health care, providers or insurers? In short, the state and others must decide what kinds of questions must be answered by this data before it is gathered. In our opinion, this has not yet been done. We are aware, however, of efforts by the Kansas Department of Health and Environment and the 403 Commission to begin asking these questions. We support these efforts and are willing to assist in any way possible.

Thank you for your consideration of our comments.

TLB / pc

TASK FORCE ON INFORMATION

The 403 Commission has begun gathering information and identifying information necessary and helpful to the Commission. For this overall purpose, the Commission will appoint a Task Force on Information composed of seven people, two of whom will be Commissioners.

One of the first responsibilities of this Task Force will be to liason with the groups undertaking the Health Care and Health Insurance study. At the request of the Kansas Hospital Association, the Kansas Medical Association, and Blue Cross-Blue Shield and in the interest of gaining necessary information for the 403 Commission, the Task Force will as one of it's function act as Steering Committee for the Health Care and Health Insurance: A Study of Factors Influencing Costs in Kansas project, designed to answer the following questions:

1) How do health care costs in Kansas compare with those in the rest of the United States?

2) What factors are driving physician and hospital costs in Kansas and how do these compare with the rest of the country?

3) Why have health insurance premiums and employers' health care costs increased so much more rapidly than physician and hospital costs? and,

4) Where are health care costs in Kansas headed over the next three years?

The above provider groups will provide approximately one-half of the necessary funds and seek grant money for the balance.

The provider groups have identified the four primary questions for which answers are sought and they have engaged consultants who will implement the project. A timeline has been set with a goal of November, 1992 for a final report.

The steering committee will be active during the implementation of the grant and will serve as a source of advice, guidance, and discourse with the consultants. It is anticipated that this relationship will provide the steering committee with knowledge of available information sources and also information bases not now available.

It is possible that corollary questions will be developed within the parameters of the four primary questions asked. When possible the consultants will address the auxiliary questions. When it is not feasible for the consultants to develop adequate data to answer the corollary questions, the Task Force will so note, and where the missing information is essential, seek other ways of obtaining it.

The Health Care and Health Insurance: A Study of Factors Influencing Costs in Kansas fulfills several functions important to completing the Commission's mission:

1) The information gathered for the purpose of answering the four primary questions of the study is essential to the 403 Commission in its deliberations over health care reform

2) Because of the participation of the 403 Task Force as steering committee, the Commission will have the opportunity identify additional information which may be provided by the study or sought later.

3) The project will provide to the 403 Commission the statistics and the key provider information necessary to evaluate the need of an ongoing, public-private health information center.

4) The data base is essential to evaluating 403 recommendations to the legislature and the estimating the cost and other effects of proposed legislation.

TESTIMONY BEFORE THE COMMITTEE ON INSURANCE

CONCERNING BILL 2528

Mr. Chairman and members of the committee. I am John Noonan, a member of the AARP State Legislative Committee of Kansas.

For several years the State Legislative Committee has recognized the need for, and supported establishment of, a Health Care Data System in Kansas. In fact, the committee has played a significant role in calling attention to the need for such a system as the issues regarding access to health care were working their way to the surface as major local and national issues. It is logical, therefore, that we endorse the concept of establishing a Health Care Data System as outlined in House Bill 2528. We believe it recognizes an important need of providing essential information required to make wise decisions which will face us all in meeting the difficult health care issues ahead.

In spite of our general support for establishing a health care data system, we do have concerns about this bill.

First, we believe that such a center would more logically be established in the Department of Health and Environment. During the summer, the Department wrote a proposal to the Robert Woods Johnson Foundation detailing how a data system could be established there. Although the request was for planning and later initiation, it did spell out a methodology which received wide support from both state agencies and private groups. The Department of Health and Environment has a system in place and a long history of collecting and analyzing health care data. Unfortunately, it does not at present have the resources to put an adequate data base in place.

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Second, we have reservations as to the advisability of putting the center in the Department of Insurance. For instance, much of the cost of medical care is associated with insurance and its costs; therefore, the commission's participation in a data system would be essential. Its focus, however would appear to be much more limited than that of the Department of Health and Environment so it would lack the broader perspective required.

Third, House Bill 2528 does not include groups outside the Department of Insurance who would be deeply involved in the process and whose advice and cooperation would be so essential for a productive effort.

Fourth, the bill focuses primarily on costs associated with medical care facilities. While these data are important, they constitute only a part of the health care costs which reside in a wide spectrum of sources such as equipment and its use, drugs, laboratory expenses, physicians costs, etc.

To repeat, we are indeed pleased that interest in a Health Care Data System is increasing and we strongly support efforts to establish a broad data base in this area. We do, however have these reservations about this bill giving the responsibility to the Insurance Commission. We support instituting a Health Care System in the Department of Health and Environment.

Testimony on HB 2186
Creation of State Health Data System

before the
House Insurance Committee
March 4, 1992

by the
Kansas Department on Aging

The Kansas Department on Aging supports a health information program for the State of Kansas. The American Association of Retired Persons deserves recognition for bringing this issue to our public agenda. Since the demise of health planning at the Department of Health and Environment good Kansas' specific data has been hard to come by. If for no other reason, Kansas decisionmakers need good data to plan for the future of Kansas citizens.

The Department on Aging supported last year's Robert Wood Johnson Foundation grant proposal by the Department of Health and Environment. We were disappointed to learn in October that the Foundation did not approve the proposal.

The Department believes that a data collection system which does not duplicate but coordinates existing data collection should be developed in Kansas.

## Health Professions

Our state needs data to plan for adequate health manpower. A report by the U. S. House Select Committee on Aging in December, 1988 on "Health Care In The 21st Century" predicted a critical shortage of health care professionals, primarily in nursing and allied health professions. However, the report found "a paucity of data on supply and demand relative to the allied health professions, e.g. mental health professionals; there is also little information on utilization."

The Department on Aging has recently discussed with Kansas State University a proposal to develop training for in geriatric orthopedics. Although we can foresee a need for these professionals in the field of rehabilitation, Kansas State University has not found the data to measure the need nor to project the demand for these professionals.

Federal agencies have concluded: "A data collection effort should be undertaken to at least quantify the supply and demand for these professions, the type of services delivered, and the trends in health care delivery" (U.S. House Select Committee on Aging, 1988, p. 22). Kansas-specific data is equally necessary.

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## Long Term Care

Long term care is an area of health planning which demands our attention today because of the cost of care and quality of life issues. Again data are hard to come by.

The Kansas Health Facilities Plan in 1986 found a large excess capacity of acute care services. The report also found that over-reliance on the inpatient setting for the delivery of long-term care services has resulted in a long-term care system which often forces the patient to fit a predetermined role. The 1986 Kansas Health Facilities Plan was the last one produced by the Department of Health and Environment. What we have now, instead, are ad hoc studies such as the Legislative Post Audit Report in 1990 on expenditures for adult care homes.

The Departments of SRS, Health & Environment, and Aging in January presented a joint plan on long term care to the Legislature. One recommendation in the plan is for a common data base among the state agencies.

Regular sources of information would be more reliable for decision making. As David Rogers, President of the robert Wood Johnson Foundation, said in his 1984 Report:

> In material terms, we will spend more than one-tenth of the nation's economy - over four hundred billion dollars this year - on health care. It simply does not make sense to be almost totally without objective "intelligence" to show what we are getting for thse health care dollars. Each day a quick glance at the newspaper tells us the relative standing of our baseball, football and hockey teams. Likewise a myriad of data is available daily on the status of American business or the economy in our major cities. Yet in health care, even fairly simple statistics are not regularly collected, or when they are, they are processed so slowly that they are not available until two to five years after the fact. (Intergovernmental Health Policy Project, Focus On ..., January 1987, p. 3).

Kansas used to have an annual plan for long term care as a part of its state health plan. That data is no longer easily available despite our current need for it.

## Discharge Planning

According to the 1990 Profiles of Kansas Hospitals by the Kansas Hospital Association, older patients accounted for 37.5 percent of hospital discharges in 1988.

A study released in 1989 by the U.S. House Government Operations Committee estimated that 330,000 Medicare beneficiaries were discharged from hospitals in fiscal year 1989 without a proper plan for post-hospital care and follow-up treatment. A significant

percentage of Medicare patient readmissions to hospitals resulted from premature discharges.

This report relied on unpublished studies and the records of peer review organizations.

Kansas-specific discharge plannning data would be useful because there aplparently is a wide range of practice between states. The link between hospital and other community services is an essential part of health care delivery.

## Conclusion

House Bill 2186 creates an 11 voting member health data commission which would include the Secretary of Aging. On behalf of Secretary Joanne Hurst, I assure you that the Department on Aging is interested in serving on such a commission. Older Kansans have a stake in health care information.

PREPARED STATEMENT TO THE JUDICIARY COMMITTEE
IN SUPPORT OF HOUSE BILL NO. 3107 ON MARCH 5, 1992

H.B. 3107 addresses a growing problem for the citizens and courts of Kansas that is preventing the prompt, expeditious and economical concluding of uninsured motorist coverage claims. This problem has been created by the growing propensity of uninsured motorist insurers at the outset of the claim to deny that the tort feasor is uninsured even though the alleged liability insurance carrier denies that it is obligated to provide coverage to the tort feasor.

This denial of liability coverage most always arises out of questions as to whether or not the tort feasor was covered as a permissive user of the vehicle under someone else's policy.

At the stage before filing suit, this grid-lock prevents any resolution by settlement since neither the uninsured motorist or alleged liability carrier believe that they should cover the plaintiff's losses. Accordingly, at an increase of expense and costs to the injured person, suit must be filed.

But the filing of suit does not really help solve the problem of determining which insurance coverage (the uninsured motorist or liability coverage) should apply to the plaintiff's damages for his or her damages. Plaintiff can only sue the tort feasor and the plaintiff's own uninsured motorist carrier. Plaintiff cannot sue the alleged liablity carrier since plaintiff has no cause of action against any liability carrier.



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Predictably, by its answer, the uninsured motorist carrier raises the defense that the tort feasor is not uninsured. The grid-lock remains and the cost and expense of litigation to the injured insured again increases because the plaintiff with the burden of proving all aspects of the claim must go forward and attempt to prove the lack of liability coverage to the tort feasor. Plaintiff must prove that indeed plaintiff's own uninsured motorist coverage applies to his damages.

This is no small matter. For plaintiff to develop what is needed by way of evidence to establish the lack of liability coverage requires the assistance of the tort feasor, the alleged liability carrier and the named insured on the liability policy. These latter two not being parties to the litigation from my experience are not overwhelmed with the thought of helping out in any manner someone who might just possibly, after all, have a claim against them. The assurances of plaintiff's counsel to the contrary are viewed at best with suspicion and at worst with outright hostility. The tort feasor obviously offers little cooperation because if plaintiff's own uninsured motorist carrier is right, the defendant has liability coverage available and the defendant-tort feasor is not going to do anything that might jeopardize that decision.

So through the expense of the discovery process, the injured plaintiff must go forward to prove issues not of liability and damages that are the basis of any damage action, but the absence of any applicable liability coverage to the defendant.

During this process, the alleged liability insurance carrier, if it chooses, can stand by and take no action. While the liability carrier may in a very narrowly defined area of factual situations be able to file a declaratory judgment action against the plaintiff, the defendant and uninsured motorist carrier to obtain a judgment declaring that its liability coverage does not afford coverage to the defendant, the alleged liability insurance carrier is not required to take such action and may elect to defend any claim against it in a garnishment proceeding in the principal case after the plaintiff has obtained a judgment against the defendant-tort feasor.

Moreover, if the alleged liability insurance carrier elects to stay out of the fray by not filing a separate declaratory judgment action, or if a declaratory judgment action is not legally possible, the plaintiff in the principal action is at risk of being faced with conflicting judgments. In the principal action, if plaintiff cannot prove the tort feasor is uninsured, then his judgment is only against the tort feasor. In either a post-judgment garnishment proceeding or a separate or a subsequent declaratory judgment action filed by the alleged insurance carrier, there can be a judgment that there is indeed no liability coverage to the tort feasor.

If the issue of this coverage could be promptly determined, once and for all, in the principal litigation, prompt settlements could be achieved without necessitating the trying of a case to conclusion before determining what coverage is to apply.

H.B. 3107 I believe fully and fairly addresses this problem of resolving in the principal case at the earliest possible moment a dispute between two insurance carriers, i.e. the uninsured motorist carrier and the alleged liability carrier.

Respectfully submitted,

David R. Hills
Supreme Court ID# 06551
Midland Bank Building
1314 North 38th Street
Kansas City, KS 66102
(913) 621-1200

DAVID R. HILLS, of Kansas City, Kansas, has been practicing law for 25 years in personal injury litigation involving industrial accidents, product liability and automobile accidents as well as workers' compensation matters. He has served in several positions with the Wyandotte County Bar Association and from 1984 to 1992 served on the Kansas Supreme Court Board of Discipline for Attorneys. He is a member of the Kansas Bar Association, Kansas Trial Lawyers Association and the Kansas City Metropolitan Bar Association. He has been admitted to practice in the Federal District Court for the District of Kansas and from time to time in other federal district courts. He has offices in Kansas City, Kansas and Lenexa, Kansas.

ALLIANCE INSURANCE COMPANY, INC.
1122 N. MAIN P.O. BOX 1401 McPHERSON, KANSAS 67460 (316) 241-2200

TO: House Insurance Committee

FROM: Richard Wilborn, CPCU

SUBJECT: House Bill 3107

My name is Richard Wilborn with the Alliance Insurance Companies of McPherson, Kansas. I would like to thank the chairman and the members of the committee for the opportunity to make a brief statement concerning House Bill 3107.

The Alliance Insurance Companies operating in eleven west central states, insure approximately 45,000 automobiles in the state of Kansas.

We are very much concerned about the impact of House Bill 3107. As you know, there are other pieces of legislation attempting to reconstruct, amend, etc., the underinsured motorist coverage in the state of Kansas.

We oppose House Bill 3107 because it requires the uninsured motorist coverage insurer to bear the burden of pleading and proving the applicability of the coverage of the alleged policy of liability insurance to the claim being made against the insurer under the uninsured motorist coverage. It will add cost to the system; it will add to the time it takes to settle and create an adversarial environment between insurer and insured.

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KANSAS
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March 5, 1992

TO: Members of the House Insurance Committee

FROM: Richard H. Mason

SUBJECT: HB 3107

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It is our understanding David Hills will testify in support of HB 3107 and will be in a position to respond to any legal questions. So as not to take any additional time of the Committee, we are submitting this written testimony.

HB 3107 provides that when there is a wreck and the tortfeasor has no insurance coverage and the injured party makes a claim under the uninsured motorist provision of their own policy and that if the uninsured motorist insurance company wants to assert the tortfeasor does in fact have insurance coverage, the burden is on the uninsured motorist insurance carrier to bring the alleged insurance company into the underlying lawsuit.

The issue is one of fairness. If the injured victim's own insurance company wants to avoid uninsured motorist coverage by asserting there is coverage elsewhere, when none probably exists, then the burden of proving there is other insurance should be on the uninsured carrier and not on the plaintiff.

As the law currently stands, if the uninsured carrier asserts there is other coverage, the plaintiff is put in the precarious position of proving the tortfeasor does not have coverage. This is an untenable position for injured victims. No plaintiff is going to sue on his uninsured motorist coverage if there is applicable liability coverage elsewhere.

Two cases are illustrative of the problem. In Bates v. Farmers, et al 91 C 2028, the plaintiff had to file an amended petition in an uninsured motorist case. The plaintiff had to allege her insurance company's denial of uninsured coverage because it did not agree the denial of liability coverage by the tortfeasor's alleged insurer was erroneous. The injured victim ended up with the burden of proving no insurance instead of the uninsured carrier having to prove there was other coverage available.

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In another case, a 70-year-old Johnson County woman was hit by a driver with a blood alcohol content of .20. The drunk driver had no liability insurance. He was driving a car he had purchased from a used car lot 3 or 4 months before the accident. The car lot sent him an executed notarized title that he never picked up from the post office, so the car was never registered or titled in the tortfeasor's name. The injured woman's medicals are $70,000.00, and she has $10,000.00 in lost wages. She has uninsured motorist coverage of $100,000.00 with State Farm. State Farm is taking the position that since title never passed to the tortfeasor, the liability insurance of the used car lot is available to the tortfeasor. This leaves the 70-year-old injured party in the position of trying to disprove the assertions of her own insurance company, State Farm.

It is truly unfair to insureds with uninsured motorist protection to be forced to disprove any number of spurious assertions and claims of the uninsured motorist carrier. It also subjects the plaintiff to increased risk of malicious prosecution for suing when there is no basis to sue. If the uninsured motorist carriers want to assert the claim there is other insurance, the burden should be on them to figure out the basis of such a claim and assume the risk of malicious prosecution for asserting frivolous claims.

We encourage you to act favorably on HB 3107.