Approved: January 17, 1995

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on January 10, 1995 in Room 423-S of the State Capitol.

All members were present.

Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolfe, Legislative Research Department
Norman Furse, Revisor of Statutes
Lois Hedrick, Committee Secretary

Conferees appearing before the committee: No conferees.

Others attending: See Guest List, Attachment 1.

The chairman announced that the committee meetings for the first two weeks willl include a conference on healthcare issues on Wednesday, to be held at the Holiday Inn City Centre, Topeka, at 1:45 p.m., and a tour of the Kansas Neurological Institute one day next week. He stated that in administering the work of the committee, conferees will be requested to provide written testimony and only give an oral overview.

Committee and staff members then introduced themselves and provided comments as to their interests in healthcare and human services and the work of the committee.

Norman Furse, Revisor of Statutes, explained his role with the committee and offered the assistance of his office to the legislators with respect to any legislative subject. Bill Wolff described his history with the Legislature as did Emalene Correll, who listed the various materials and information sources that the Research Department provides.

Ms. Correll proceeded to outline the various laws and activities relating to healthcare reform in the state's structure from 1990 (see Attachment 2, pp. 1-2).

Bill Wolff discussed the various legislation enacted concerning health insurance reforms (see Attachment 2, pp. 2-6) and suggested that if the committee wants to move on universal based health coverage, Kansas has already taken significant actions in legislation and established various committees to perform some oversight. At the same time, the private healthcare sector has undertaken many changes to its structure, which continues more intensely at this time. Mr. Wolff suggested that these changes alert legislators to be watchful.

Ms. Correll reported that the state of Minnesota established three statewide health care networks that have proven to be somewhat ineffective. They have found the networks do not afford total access to coverage and various buyouts and organizational restructures in the private sector continue. She suggested that Minnesota's experience may enlighten the Kansas efforts in this subject area.

Ms. Correll then discussed the various healthcare reform laws recently enacted (see Attachment 3).

Representative Haley asked about the administration of grants to medical students at the University of Kansas Medical Center, and Ms. Correll replied that if students do not apply for grants in their first academic year, eligibility is not available in the years after. Representative Wells inquired about the Tort Claims Act and Mr. Furse replied that Attachment 2, p. 4, describes the changes made in Kansas during the last 20 years.

The meeting was adjourned at 3:07 p.m.

The next meeting is scheduled for January 11, 1995.

HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES EALTH SERVICES COMMITTEE GUEST LIST

DATE: JANUARY 10, 1995

NAME	REPRESENTING
KEITH R LAWRENCE	CHRISTIAN SCIENCE COMM. ON PUBLIC EDUCATION FOR KS
RICHARD WATSON JWD	
Stacey Simpson	Hein, Ebert & Weir, Chtd.
Tom Bell	KS. Hospital Assn.
Rich Guthrie	Health Midwest
Mary Ellen Conlee	Health Affiliates, Inc
Amy Elwell	
Carl Schmidtberger	Kansas Dental Assn.
James Crawford	Intern
John J Federico	Pete McGill + Assoc
Michelle Peterson	Ks. Governmental Consulting
TREVA POTTER	REBECCA RICE ASSOC.
GARY Robbins	Ks Optometric Assn
Larry Buening	Bd of Healing Arts
Mark Stafford	Bd of Healing Arts

HOUSE H&HS COMMITTEE
1 – 10 – 1995
Attachment 1

MEMORANDUM

Kansas Legislative Research Department

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Topeka, Kansas 66612-1504
Telephone (913) 296-3181 FAX (913) 296-3824

May 13, 1994

Re: Health Care Reform Legislation Outline

Government Structure

- Joint Committee on Health Care Decisions for the 1990s -- created in 1990
  - received reports of the 403 Commission and maintained broad view of health in Kansas
  - X repealed by passage of H.B. 2633 in 1994

- Commission on Future of Health Care (403 Commission) -- created in 1991
  - reported in January, 1994; introduced H.B. 2699
  - statutes creating the Commission expire July 1, 1994

- X Health Care Reform Legislative Oversight Committee -- created in 1994 (HB 2633)
  - specified duties to examine changes in federal laws and propose changes in Kansas law necessary to meet federal requirements
  - five advisory subcommittees -- administration, insurance, employer, provider, and consumer
  - expires December 31, 1998

- Health Care Database Governing Board -- created in 1993
  - seven members; develop policy regarding the collection of health data and procedures for ensuring the confidentiality and security of the data collected
  - health insurance data concerning rates charged and losses experienced by insurance companies collected by the Insurance Commissioner is to be turned over to the Board for its use -- Board may charge insurers a fee for data

HOUSE H&HS COMMITTEE
1 - 10 - 1995
Attachment 2-1

X indicates 1994 legislation (See attached summaries)

- The Health Care Provider Cooperation Act -- enacted in 1994 (HB 2709)
  - articulates the intent of the state to exercise state supervision over health care provider agreements that might raise an antitrust issue under state or federal laws
  - agreements between or among providers for, among other things, sharing, allocation, or referral of patients, personnel, medical, diagnostic or laboratory facilities, or other services offered by health care providers may be submitted for review and oversight of the state for antitrust purposes
  - the Secretary of Health and Environment evaluates the agreements as to advantages and disadvantages and, if the advantages outweigh the disadvantages, the Secretary issues a certificate of public advantage, subject to annual review

- Regulation of utilization review organizations in Kansas -- 1994 S.B. 487
  - unless exempted by the Insurance Commissioner, no utilization review organization may conduct such review activities in Kansas without obtaining a certificate from the Commissioner on and after May 1, 1995
  - the Commissioner is to establish the standards by rules and regulations governing the conduct of utilization review activities performed in this state or affecting residents of this state

Health Insurance Reform

- Underwriting in group health insurance prohibited -- enacted in 1988
  - first step in ending practice of individual underwriting in groups

- Group health insurance regulation
  - no person eligible for coverage under a group may be excluded from group coverage -- H.B. 2001 in 1991
  - no policy may limit or exclude benefits for specific conditions -- H.B. 2001 in 1991 and S.B. 561 in 1992
  - policy may have one-year waiting period for preexisting condition -- H.B. 2001 (waiting period reduced to 90 days by 1994 H.B. 2633 not only for groups but for all health insurance contracts, groups, and individuals)
  - once eligible for benefit, eligibility is portable to another group -- H.B. 2001 in 1991 (portability expanded from groups, individual contracts, self-funded groups, municipal pool fund groups, and small employer groups -- groups 3 to 50 -- by 1994 H.B. 2633)
  - a cap was placed on maximum annual premium increases at 75 percent

- Small Employer Health Benefit Act -- H.B. 2610 in 1990
  - allowed two or more small employers (with 25 or fewer employees) to establish a benefit plan (expanded to 50 employees by H.B. 2440 in 1992)
  - created tax incentive to provide insurance for employees
  - no benefit plans have been developed

- Small Employer Health Care Plan -- S.B. 561 in 1992
  - guaranteed issue to any group -- 3 to 25 employees -- seeking coverage (group size enlarged to 50 employees by 1994 H.B. 2633)
  - board of directors of benefit plans create benefit levels, coinsurance charges, deductibles, etc.
  - all carriers writing in Kansas required to offer basic and standard benefit plans
  - carriers allowed to classify risks, but premiums vary within certain percentage limitations (three-year rate compression to move rates to middle of classification and to the middle among classifications); however, no rate could increase by more than 75 percent
  - allowed for reinsurance of certain risks
  - waiting periods and portability of benefits same as for regular groups, etc., by virtue of 1994 H.B. 2633

- Kansas Uninsurable Health Insurance Plan -- 1992
  - guaranteed access to health insurance to uninsurable individuals
  - Kansas Health Insurance Association to prescribe benefits under the plan
  - carriers mandated to participate in plan and may claim premium tax offset for certain losses incurred from plan participation
  - waiting period for coverage reduced to 90 days on and after May 1, 1994 by virtue of 1994 S.B. 566 and benefits are portable by virtue of 1994 H.B. 2633

- Accident and Health Claims Filing
  - Insurance Commissioner required to devise universal claim form to be used by all insurance companies, HMOs, etc. -- H.B. 2216 in 1991; forms were in place in the spring, 1993
  - Insurance Commissioner to report on the development of a uniform electronic data interchange, including formats and standards; the Commissioner reported to the Legislature in the spring, 1993 -- S.B. 722 in 1992

Healing Arts Referrals

- Notice of referral by a health care provider

  - failure of a health care provider to notify a patient that the provider holds a significant investment interest in a health care entity to whom the patient is referred is declared unprofessional conduct and subjects the licensee to potential disciplinary action by the Board of Healing Arts -- S.B. 19 in 1993

Tort Reform

- The process of tort reform has been on-going in Kansas for nearly 20 years and includes:

  - comparative fault -- adopted in 1974 and abolished the joint and several liability system; recovery is barred if plaintiff's fault exceeds 49 percent

  - caps on damages -- a 1988 law imposed a $250,000 cap on noneconomic loss for all personal injury actions

  - punitive damages -- a 1988 enactment placed a cap on punitive damages in all personal injury actions of the lesser of either the annual gross income of the defendant or $5 million

  - screening panels -- for medical malpractice actions were made permissive in 1976

  - statute of limitations -- a 1976 law established an overall ten-year statute of limitations from the time of the injury for bringing a medical malpractice action

  - attorney fees -- in medical malpractice actions, fees must be approved by the judge at an evidentiary hearing (the Kansas Supreme Court in 1988 adopted a rule dealing with contingency fee arrangements)

  - mandatory settlement conferences in medical malpractice cases

  - modified *ad damnum* clause to prohibit pleadings from listing a specific amount of damages if the amount exceeds $10,000

  - other tort reform measures -- include a no-fault auto insurance law; a product liability insurance law; sanctions against frivolous lawsuits; itemized jury verdicts; immunity for nonprofit organization volunteers; indemnity authorization for corporate officers and directors

  - collateral source rule -- was abolished in 1988 in actions where the damages request exceeds $150,000. The law was declared unconstitutional in 1993. The 1994 Legislature reenacted the law; however, the Governor vetoed the measure and the veto was sustained.

Accident and Health Insurance

H.B. 2633 enacts additional changes to the Kansas statutes governing the eligibility for coverage for health insurance, the portability of benefits between and among various payment mechanisms for health care, and adds more persons covered by group health insurance to the rate compression feature of the Kansas Small Employer Group Plan law. Finally, on an unrelated matter, the bill imposes on health maintenance organizations (HMOs) the same duty as is imposed currently on insurers, *i.e.*, to provide to an applicant for enrollment the specific reason or reasons for rejection of the application for services (the adverse underwriting decision).

The bill expands the portability of benefits for health care by requiring that waiting periods for coverage be waived not only for movement from one group policy to another group policy as required by law, but for movement from an individual policy, from a self-insured plan (ERISA), from a multiple employer welfare association specifically authorized by Kansas law, or from a municipal funded pool. The same terms for portability are extended to persons covered under the Kansas Small Employer Group Plan law effective May 1, 1994. Credit for waiting periods served under any noted type of coverage is portable for a period of 31 days from the date of termination of coverage under one type of policy to the beginning of coverage under a new policy. Further, the initial waiting period under any group or individual policy for a pre-existing condition is reduced to a period of time not to exceed 90 days.

The term "small employer" as defined in the Kansas Small Employer Group Plan law is redefined to include an employer of not fewer than three nor more 50 employees (the law had included employers with not fewer than three nor more than 25 employees). Further, the law relating to small employers covered under a trust arrangement or a policy issued to an association is amended to increase the number of employees permitted in such arrangements from 25 to 50.

To moderate the impact of rate compression on employer groups of between 25 and 50 employees, the rate compression feature in current law is phased in over a three-year period. Groups in the three to 25 size range continue in the compression process to their first renewal.

Legislative Oversight Committee. H.B. 2633 creates a 12-member joint legislative committee to be known as the Health Care Reform Legislative Oversight Committee charged by law with overseeing any changes in state laws and regulations necessitated by federal law and with implementing health care reform that, to the fullest extent possible, is specific to Kansas needs. Three members of the committee are appointed each by the Speaker of the House, the President of the Senate, the Minority Leader of the House, and the Minority Leader of the Senate. The President of the Senate names the first chairperson and the Minority Leader of the House will name the vice-chairperson. The chair alternates annually as does the process for naming the chair. The Secretaries of Health and Environment and Social and Rehabilitation Services, the Director of the Budget, and the Commissioner of Insurance are designated as advisors to the Oversight Committee. All other state officers and employees are required to provide assistance to the Committee.

The duties of the Health Care Reform Legislative Oversight Committee include: examining changes in federal laws and proposing changes in Kansas laws necessary to meet federal requirements; cooperating and interacting with federal agencies responsible for health care reform; considering health care financing and delivery options now in effect; working cooperatively with relevant state and federal agencies, health care providers, payers, and consumer groups in the development of an integrated health plan for all Kansans; receiving, analyzing, and making recommendations for the health care data base; developing plans for health care cost containment; studying and making recommendations for legislative action to integrate health care financing and coverage with other states; recommending actions necessary to assure accessibility of services for residents of underserved areas; providing recommendations if federal

or state laws require inclusion of the medical care components of workers compensation and automobile insurance into health care coverage; and making recommendations on tort reform and state and federal antitrust reform or modifications.

The Committee is authorized to employ an executive secretary who is to be in the unclassified service under the Kansas Civil Service Act and to appoint advisory committees as it deems appropriate; but, five advisory subcommittees are required -- administration, insurance, employer, provider, and consumer. The Department of Health and Environment is designated as the contact agency for the State of Kansas for the purposes of federal health care reform measures. However, the Department is prohibited from making decisions regarding federal health care reform measures not otherwise authorized by existing law or the Legislature.

Finally, the statutes creating the Joint Committee on Health Care Decisions for the 1990s are repealed and the statutes creating the Health Care Reform Oversight Committee are set for expiration on December 31, 1998.

Health Care Provider Cooperation Act

H.B. 2709 creates the Health Care Provider Cooperation Act which is made up of seven new statutes created by the bill. The bill sets out legislative findings, including the statement that cooperative agreements among health care providers can foster improvements in the quality of health care for Kansas citizens, can moderate increases in costs, can avoid duplication of resources, and can improve access to needed services in rural areas. The newly created legislation further states that, because cooperative agreements may require health care providers to collaborate on the provision of services thereby raising the issue of anti-trust effects, state regulatory oversight is necessary to ensure that the benefits of agreements outweigh any disadvantage attributable to any reduction in competition resulting from such agreements. The new act articulates the intent of the state to exercise state supervision over such agreements, to provide protection for the public and to offset any loss of protection that would otherwise arise from competition.

Under the provisions of H.B. 2709, the term "cooperative agreement" is defined as an agreement among two or more health care providers for the sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities; or medical, diagnostic, or laboratory facilities or procedures; or other services traditionally offered by health care providers. Health care provider is broadly defined in terms of both individual and institutional providers.

The new legislation sets out the procedure to be followed when a health care provider wishes to enter into a cooperative agreement with other health care providers and to bring such agreement under the purview of the state for anti-trust purposes. Parties to the agreement must apply to the Secretary of Health and Environment for a certificate of public advantage approving and governing the agreement. The Secretary must review and evaluate the agreement in accordance with the potential benefits and disadvantages set out in the legislation and must hold a public hearing. If the Secretary finds the benefits of the cooperative agreement outweigh the disadvantages, a certificate of public advantage approving and governing the cooperative agreement is to be issued. Any approved agreement must be reviewed annually by the Secretary and, if the Secretary finds the agreement no longer meets the statutory requirements, proceedings to terminate the certificate of public advantage issued pursuant to the new laws must be initiated.

The new legislation does not apply to any agreement already in effect on the effective date of H.B. 2709, to any agreement for which no application for a certificate of public advantage has been submitted, nor to any authorized activity of a rural health network. The latter are covered by legislation enacted in 1992. A cooperative agreement for which a certificate of public advantage has been issued is a lawful agreement and, if the parties to an agreement submit an application for a certificate of public advantage, the conduct of the parties in negotiating and entering into an agreement is lawful.

An advisory committee of not to exceed five health care providers is created by H.B. 2709. One member is to be appointed by the Governor. The Speaker and Minority Leader of the House and the President and Minority Leader of the Senate are each to appoint one member. Members are to serve without compensation, subsistence, or mileage allowances. The committee created by H.B. 2709 is to advise the Secretary of Health and Environment on the administration of the new laws and to make recommendations to the Secretary concerning applications for certificates of public advantage and the termination of such certificates.

H.B. 2709 will become effective upon publication in the *Kansas Register*.

Utilization Review Organization Regulated

S.B. 487 creates new law to regulate utilization review organizations in Kansas. The bill directs the Insurance Commissioner, with the advice of an advisory committee, to establish standards governing the conduct of utilization review activities performed in this state or affecting residents of this state by utilization review organizations. Unless granted an exemption by the Commissioner, no utilization review organization may conduct such review activities in this state or affecting residents of Kansas on or after May 1, 1995, without first obtaining a certificate from the Commissioner.

Review organizations seeking to provide services in this state, among other things, must make application to the Commissioner, provide a summary of the qualifications and experience of persons who will perform the review functions, and pay a $100 fee ($50 annual continuation).

The certification requirement does not apply to: an agency of the federal government or a person or agency acting on behalf of the federal government; a federally qualified health maintenance organization performing review functions for its own members; a person employed or used by a utilization review organization authorized to perform utilization review in Kansas, *e.g.*, nurses and other health care providers; Federal Employee Retirement Income Security Act (ERISA) health benefit plans; or hospitals, home health agencies, clinics, health care provider offices or others doing in-house utilization review, unless that review is related to the denial of payment for hospital or medical services in a particular case.

Additionally, any utilization review organization accredited by and adhering to the national utilization review standards approved by the Utilization Review Accreditation Commission (URAC) and any utilization review organization subscribing and adhering to the voluntary guidelines established by the Kansas City private review group, and such other groups as the Commissioner may approve will be required only to make an application for certification (fees and the filing of other information are waived).

To assist the Commissioner, the bill creates an advisory committee consisting of 13 members as designated. The committee advises the Commissioner on, among other things, the adoption of rules and regulations establishing utilization review standards and utilization procedures.

Utilization review organizations are prohibited from agreeing to perform any utilization review activity for compensation which is contingent in any way upon frequency of denials, costs avoided by denials or reduction in payment of claims or other results which may be adverse to the needs of patients as determined by the attending health care provider. Each utilization review organization must have written procedures for assuring that patient-specific information obtained during utilization review will be kept confidential and be used solely for the purposes of utilization review, quality assurance, discharge planning, and catastrophic case management. All records exchanged between a health care provider or patient and a utilization review organization will not be subject to discovery, subpoena, or other means of legal compulsion and will not be admissible in evidence in any judicial or administrative proceeding other than a disciplinary proceeding by the Board of Healing Arts or other agency of the state regulating health care providers.

The Act will be applicable to utilization review organizations conducting review for mental health, chemical dependency, chiropractic, optometric, podiatric, dental, or any other health care services other than the practice of medicine and surgery at the time review standards are adopted by the Commissioner.

Finally, S.B. 487 amends two statutes relating to statistical plans for accident and sickness loss and expense data to designate the Secretary of Health and Environment as the statistical agent responsible for gathering, receiving, and compiling the data required by the statistical agent responsible

for gathering, receiving, and compiling the data required by the statistical plan or plans developed or approved under existing law. (The Secretary already is the administrator of the health care database under K.S.A. 65-6804.)

The Secretary is authorized to establish fees to cover the expenses incurred in accumulating and processing the data gathered and to report an entity not in compliance with the reporting requirements of the statutes to the Insurance Commissioner who has authority to impose appropriate penalties.

The Secretary of Health and Environment and the Insurance Commissioner are authorized to adopt jointly rules and regulations necessary to implement the provisions of the act.

Waiting Periods for Uninsurables

S.B. 566 relates to accident and health insurance and amends K.S.A. 40-2124, one statute in the Kansas Uninsurable Health Insurance Plan Act. The bill provides that, on and after May 1, 1994, the waiting period for persons with preexisting conditions is reduced from 12 months to 90 days. The reduced waiting period applies to persons covered under the plan or making application for coverage under the Act. The board of directors of the plan retains authority, after this plan year, to reduce or increase the waiting period; however, the maximum waiting period cannot exceed 180 days.

The bill is effective upon publication in the *Kansas Register*.

1988 - 1993

MEMORANDUM

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May 27, 1993

To: Joint Committee on Health Care Decisions for the 1990s and Interested Parties

Re: Health Care Reform Legislation

Government Structure and Health Care Reform

Joint Committee on Health Care Decisions

H.B. 2609 created in 1990 a 12-member Joint Committee on Health Care Decisions for the 1990s. The members of the Joint Committee are to be the chairperson or a member designated by the chairperson and the ranking minority member or a member designated by the ranking minority member of each of the following standing committees of the Legislature: the House and the Senate Committees on Public Health and Welfare; the House Committee on Appropriations and the Senate Committee on Ways and Means; and the House Committee on Insurance and the Senate Committee on Financial Institutions and Insurance. The chairperson of the Joint Committee will be a House member designated by the Speaker of the House in odd-numbered years and a Senate member designated by the Senate Committee on Organization, Rules and Calendar in even-numbered years. The bill directs the Joint Committee on Health Care Issues for the 1990s to address policy priorities appropriate for health care in Kansas; problems of access to health care services; rural health care issues; coordination of the delivery of health care services; financing of health care by the public and private sectors; initiatives in health care policy, delivery, and financing developed by the public and private sectors in other states and by the federal government; and such other matters relating to health care in Kansas as directed by the Joint Committee. The Joint Committee is authorized to introduce legislation and will be subject to the same restrictions on meetings as other joint committees of the Legislature.

Commission on Future of Health Care

S.B. 403 created in 1991 a quasi-governmental corporation that is to be known as the Kansas Commission on the Future of Health Care, Inc. The purpose of the Commission is: (1) to develop a long-range health care policy plan, including both short and long-term strategies; (2) to identify social values of Kansans; and (3) to provide a forum for Kansans to participate in the development of health policy. The Commission is charged with involving interested citizens directly in the development of health policy by establishing a network of "town hall" meetings throughout the state to allow Kansans to participate in open discussion about health policy matters. Commission reports required by the act are to include proposals for new laws and recommendations for changes in existing laws and rules and regulations, and the Commission is to monitor such recommendations to encourage their implementation. The Kansas Commission on the Future of Health Care, Inc., is

given specific powers enumerated in the legislation as well as those other powers necessary to achieve the purposes of the Commission, including the authority to apply for and accept donations, grants, and services or property from the federal government, any governmental agency, any not-for-profit entity, and from for-profit entities in amounts not in excess of $20,000. The Commission is directed to report at least semiannually to the Governor and to the Joint Committee on Health Care Decisions for the 1990s concerning the activities of the Commission and any findings and recommendations developed by the Commission. The final report of the Commission is due on or before June 30, 1994.

The Commission is exempt from specified taxes levied by the state, exempt from state purchasing laws, and may request assistance from legislative and other state agencies. All officers and employees of the Commission are to be considered to be state employees and the Commission itself considered a state agency for payroll, deferred compensation, retirement, employment security, workers' compensation, health benefits, Social Security, and tax purposes. Nothing in the bill is to be construed as placing any officer or employee of the Commission in the civil service system.

The Commission on the Future of Health Care is to be governed by an eleven-member board of directors composed of seven directors appointed by the Governor from nominees submitted by organizations set out in the bill and a person trained in medical and health care ethics and four additional directors, who are not providers of health care, appointed by the majority and minority leadership of the House and Senate. Directors will serve until July 1, 1994, when the provisions of the act expire, and will elect a chair and vice-chair from among the membership of the board.

S.B. 403 makes a "no limit" appropriation of all moneys raised under the provisions of the legislation for FY 1992 and credited to a special revenue fund created by the bill available for expenditure by the Commission. Substitute for H.B. 2640 provides for the transfer of $50,000 from the State General Fund to the Future of Health Care Fund created by the bill for operating expenditures in FY 1992.

Health Care Database

Sub. for S.B. 118 created in 1993 a new act under which a health care database is to be created and health-related information is to be developed.

The bill creates a seven-member health care data governing board which is directed to develop policy regarding the collection of health data and procedures for ensuring the confidentiality and security of the data collected. The board, which is to include appointees of the Kansas Medical Society, the Kansas Hospital Association, the Executive Vice-Chancellor of the University of Kansas School of Medicine, and members appointed by the Governor representing health insurers or other commercial payors, adult care homes, an institute or center associated with the University of Kansas Department of Health Services Administration, and consumers, will be chaired by the Secretary of Health and Environment or the Secretary's designee. The Secretaries of Health and Environment and Social and Rehabilitation Services and the Insurance Commissioner or their designees are to serve as nonvoting members of the board. The chairperson of the health care data governing board is authorized to appoint a task force or task forces composed of interested citizens and providers of health care to study technical issues associated with the collection of health care data. At least one member of any such task force must be a member of the board.

Under the provisions of Sub. for S.B. 118, the Secretary of Health and Environment is to administer the health care database and to receive data from medical care facilities, psychiatric facilities, and third-party payors who are required by the new legislation to submit data annually to the Secretary as prescribed by the health care governing board created by the bill. The Secretary,

as directed by the health care data governing board, may contract with an organization that is experienced in health care data collection to collect data from medical care facilities and to build and maintain the database. The Secretary is required to adopt rules and regulations, approved by the board, governing the acquisition, compilation, and dissemination of all data collected pursuant to the act. The Secretary may make data available to interested parties on the basis prescribed by the board and directed by rules and regulations.

The Secretary of Health and Environment is required to make an annual report to the Governor and the Joint Committee on Health Care Decisions for the 1990s. Three years after enactment of the legislation a performance audit is to be conducted, either by or under contract to the Legislative Post Auditor, for the purpose of identifying total costs to the state and data providers and the benefits of the health care data program. The audit report is to be submitted to the Legislature at the beginning of the 1997 Legislative Session.

The Department of Health Services Administration of the University of Kansas and any institute or center established in association with the Department is authorized by Sub. for S.B. 118 to request data from public, private, and quasi-public entities for the purposes of conducting research, policy analysis, and the preparation of reports describing the performance of the health care delivery system. The Department may request data for the same purposes from any quasi-public or private entity which has data deemed necessary by the Department of Health Services Administration.

Health Insurance Reform

(a) Group

Underwriting in Group Health Insurance

S.B. 539, enacted in 1988, amended K.S.A. 40-2209 which related to group accident and health insurance, to prohibit any policy providing benefits to any member of a single employer group from containing any provision preventing any employee from insurance coverage, with some exceptions. An employee or dependent who did not enroll by the end of an open enrollment period could be subject to a waiting period, not to exceed one year, for any preexisting condition and any hospitalization in progress at the time of enrollment need not be covered. The group plan could provide for participation requirements and define "full-time" employee for the purposes of participation.

Health Insurance Data

H.B. 3027, passed in 1990, requires the Insurance Commissioner, starting in 1991, to develop or approve statistical plans for the filing of loss and expense experience by health insurance companies, HMOs, and Blue Cross/Blue Shield. The data must be available at least annually to aid the Commissioner and others in determining whether the rates being charged are, in fact, reasonable. The statistical plans could be required to contain reporting of expense experience for items specific to Kansas *i.e.*, certain mandates.

The Commissioner is given authority through rules and regulations to develop the plans, but is required to consider the rating systems and various insurance classifications that are already filed, as well as the rating systems in other states.

The Commissioner is authorized to designate recognized trade associations or other agencies to assist in gathering the experience data.

Small Employer Health Benefit Act

H.B. 2610 created in 1990 the Small Employer Health Benefit Act under which any two or more employers who qualify under the act may establish a small employer health benefit plan and contract with carriers for health insurance as described in the act. To qualify as small employer under the act the employer must employ no more than 25 employees, not have contributed to any health insurance premium on behalf of any employee in the preceding two years and make a minimum contribution as set by the plan toward the premium incurred on behalf of a covered employee. In order to encourage small employers to enter into a plan created under the act, any insurance provided under a small employer health benefit plan is exempt from mandates and is exempt from premium tax. In addition, the employer who provides insurance under a plan created pursuant to the act may be eligible for a tax credit and any contribution made by the employer toward the premium is not to be counted as income to the employee for purposes of Kansas income tax. The Small Employer Health Benefit Act was amended by the 1992 Legislature to any employer with 50 or fewer employees.

Also in 1990, the Legislature amended the Municipal Group-Funded Pool Act that allows municipalities to pool their workers' compensation liability. The Act was expanded to allow the pooling of liability for health and accident insurance and life insurance. The effect of the 1990 action was to make health insurance coverage available and, perhaps, at a rate less than the rate at which the individual municipality could purchase coverage for employees.

Small Employer Health Benefit Plans – Expansion

H.B. 2440 expanded in 1992 the availability of small employer health benefit plans authorized by K.S.A. 1991 Supp. 40-2242 to certain businesses by increasing the maximum number of eligible employees from 25 to 50.

Group Health Insurance Regulation

H.B. 2001, enacted in 1991, made a number of changes in the regulation of group accident and sickness insurance. The bill amends K.S.A. 1990 Supp. 40-2209 to state:

> that no person eligible for coverage under a group may be excluded from group coverage;
>
> that the statutory right to group coverage exists only at the time of initial eligibility and ends 31 days after that date;
>
> that eligibility applies to all Kansas insureds regardless of the place of issuance of the policy (extraterritoriality);
>
> that no policy may limit or exclude benefits for specific conditions existing at or prior to the date of coverage;

that a policy may establish up to a one year waiting period for conditions diagnosed, treated, or for which advice was sought or received in the 90 days prior to the effective date of coverage;

that the provisions for no exclusion for specific conditions with possible waiting periods applies to all Kansas insureds regardless of the place of issuance of the policy;

that, to the extent any waiting period is served under a "replaced" policy, it shall be considered served under a new policy with no gap in coverage (portability); and

that, among other things, any group policy may impose participation requirements and define full-time for purposes of determining eligibility for coverage.

K.S.A. 40-2215, concerning the filing of forms, classification of risks, and the premium rates pertaining thereto, also is amended to require:

that all forms, classification of risks, and the premium rates for any group or blanket policy or certificate of accident and sickness insurance be filed with the Insurance Commissioner prior to their use -- "file and use" (the provision would allow all insurers, including nonprofit medical and hospital service corporations BC/BS and health maintenance organizations whose rates are currently subject to approval prior to their use);

that rates charged to any group covered by the statute be prohibited from increasing by more than 75 percent in one year unless the insurer can clearly document a "material and significant change in the risk characteristics" of the group.

that any risk classification, premium rates, etc., shall not establish an unreasonable, excessive or unfairly discriminatory rate, discriminate against any individuals eligible for participation in a group, or establish rating classifications within a group that are based upon medical conditions;

that the Commissioner could at any time, after right of hearing is extended, disapprove any rate filed; and

that violations of the amendments to K.S.A 40-2215 (e) would be treated as violations of the Unfair Trade Practices Act and subject to the penalties prescribed in that Act.

Other statutes applicable to nonprofit dental service corporations, nonprofit optometric service corporations, nonprofit medical and hospital service corporations, and nonprofit pharmacy service corporations are amended to make the provisions of the bill applicable to those entities. Statutes relating to municipal group-funded pools, small employer health benefit plans organized under K.S.A. 40-2241 (1990 H.B. 2610), health maintenance organizations and captive insurance companies created under K.S.A. 1990 Supp. 40-318 are all made subject to the provisions of the bill.

Small Employer Group Health Benefit Plan

S.B. 561, passed in 1992, required, on and after May 1, 1993, every carrier issuing or maintaining health benefits plans covering small employers, as a condition of transacting such business in Kansas, to offer at least a basic and a standard small employer health care plan to any

small employer group seeking such coverage (guarantee issue). For the purposes of S.B. 561, a "small employer" generally is defined as one with 25 or fewer employees; however, a group covered under the plan may continue in the plan even though the group may have grown beyond the cap of 25 if the board and the carrier agree to its continuation. "Carrier" is defined to include insurance companies, nonprofit medical and hospital service corporations, and health maintenance organizations.

Health benefit plans made available to small employers will be designed by an 11-member board of directors created pursuant to S.B. 561 and will identify benefits levels to be provided as well as any deductibles, coinsurance factors, and exclusions and limitations. The board of directors also is to serve as the governing body of the reinsurance program that will be created pursuant to the bill.

S.B. 561 applies the existing statutory mandates relating to providers to both the basic and standard health benefits plans that are required to be offered and sold to small employers. Further, the board of directors shall review and recommend the inclusion of specified benefits set out and other health services in both the basic and standard plans, subject to the approval of the Insurance Commissioner and subject to the development of a plan that is cost effective and meets the most critical needs of small employers and their employees. The board is permitted but not required to incorporate provisions in the plans that direct insureds to the most appropriate and cost effective available service provider.

Since carriers are required to offer health care plans to any small group soliciting such coverage, the bill allows the carrier to classify the groups for purposes of establishing premium rates. However, the health status or past claims experience of the small group may not be used in determining the classifications. Carriers may establish not more than a one-year waiting period for a pre-existing condition, *i.e.*, is a condition for which diagnosis, treatment, or advice was sought or received within six months immediately preceding the effective date of coverage. The bill allows carriers to adjust premium rates based on specific formulae set out and subject to annual actuarial certification of compliance to the Insurance Commissioner. In no case, however, can an annual premium increase more the 75 percent over the previous rate.

Further, because of the guarantee issue provision of the bill, S.B. 561 authorizes reinsurance of certain risks through the Kansas Small Employer Health Reinsurance Program. The Program is authorized to reinsure only group risks with the original carrier being required to retain specific amounts of liability for the group reinsured. If the Program should have insufficient funds to cover losses, assessments would be made first upon carriers with risks in the Program and, secondly, to all writers of accident and sickness insurance policies or contracts in Kansas. Maximum assessments would be established that might be levied upon the carriers and a second tier of assessments will exclude from the assessment ratio any premium earned by a small employer carrier from small employer plans that are mandated by the bill.

Health Insurance Reform

(b) Individual

Kansas Uninsurable Health Insurance Plan

H.B. 2511, also passed in 1992, created a new act to be known as the Kansas Uninsurable Health Insurance Plan Act, under which a nonprofit legal entity that will be named the Kansas Health Insurance Association is created to make limited health insurance available for eligible persons who are unable to secure health insurance in the market or are unable to secure such insurance at a premium rate that is less than that set for participants in the limited coverage to be marketed by the Association. Insurers and fraternal benefit societies providing "health insurance" as that term is defined in the bill; health maintenance organizations; Blue Cross-Blue Shield and dental and optometric nonprofit health care service plans; multiple employer trusts; associations or other organizations that provide members health care services or benefits; group funded pools; and certain self insured health benefit plans are required to participate in the Association. Association members share the risks and costs of the insurance that is to be made available through the Kansas Uninsurable Health Insurance Plan developed by a board of directors selected by members of the Association and approved by the Commissioner of Insurance.

Among other requirements, the operating plan developed by the Kansas Health Insurance Association must provide for appropriate cost control measures, including preadmission review, case management, utilization review, and exclusions and limitations on the treatments and services covered under the plan; for assessments against members of the Association; and for a program to publicize the availability of insurance under the plan. The insurance to be offered may cover only those health care expenses enumerated in the bill, including such limitations and optional benefits levels as prescribed by the plan. The laws mandating coverage of specific services or benefits are not applicable to insurance offered under the plan, but the mandates relating to coverage of the services of specific health care providers are to apply. The plan may, however, incorporate provisions that direct covered insureds to the most appropriate, lowest cost health care provider and, subject to the approval of the Commissioner of Insurance, the board of directors must review and recommend the inclusion of coverage for mental health services and such other primary and preventive health services as it determines will not materially impair affordability of the plan. All coverage is to be subject to copayments and deductibles as set by the board of directors, subject to limitations set out in the legislation. At least one option must provide for a minimum annual deductible of $5,000, and any coverage under the plan is to be subject to a maximum lifetime benefit of $500,000 per individual. In the first two years of operation of the plan, coverage must exclude any charges or expenses incurred for a preexisting condition for 12 months following the effective date of the coverage. In succeeding years exclusion of preexisting conditions is to be determined by the board, but may not exceed 12 months. Any applicant for insurance provided under the plan is to be provided with a form for making a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition that is in substantial conformance with the form in the Kansas Natural Death Act.

In the first two years of the plan's operation, rates are required to be set in an amount that is estimated by the board to cover the cost of all claims and the expense of operating the plan. In subsequent years, the premium rate must be reasonable in terms of the benefits provided. Premium rates and rate schedules may reflect appropriate risk factors such as sex, age, and geographic location and take into consideration appropriate risk factors in accordance with accepted actuarial and underwriting practices. Rates may not be based on the health conditions or illness of the applicant for insurance. All members required to participate in the Association are subject to

an annual assessment to pay a proportionate share of losses incurred by the plan during the previous year. Any net gains would be held to offset future losses or reduce future premiums. In addition to any losses to be offset by assessments, all members of the Association can be assessed for the initial costs of developing and implementing the insurance plan to the extent that funds authorized to be loaned from the Pooled Money Investment Board in the first four years are insufficient to pay such initial costs. Eighty percent of the assessment made against a member, except for those made during the first four years of operation, can be claimed as a credit against the member's premium or privilege tax. In order to be eligible for insurance under the plan created by the Kansas Health Insurance Association, an individual must have been a Kansas resident for at least six months prior to applying for insurance and meet one of the following criteria:

- had health insurance coverage involuntarily terminated other than for nonpayment of a premium; or
- applied for health insurance and been rejected by two carriers because of health conditions; or
- applied for health insurance and been quoted a premium that is more than 150 percent of the premium set by the plan in the first two years of the plan's operation or, in succeeding years, is in excess of the plan's premium rate in an amount set by the board; or
- been accepted for health insurance subject to a permanent exclusion of a preexisting condition.

No person is eligible for coverage under the plan who is a recipient of Medicaid, eligible for Medicare, or for any other public or private program that provides or indemnifies for health services, or if such person has access to health insurance through an employer-sponsored group or self-insured plan, has had coverage under the Association plan terminated within the preceding 12 months, or has received accumulated benefits in excess of the lifetime limit established under the law.

Providers of health services that are to be indemnified through the insurance offered under the plan would have to enter into provider agreements with the plan under which rates of reimbursement for covered services would be set by the board, and no provider of health care services could collect an additional fee or charge from the insured except authorized copayments and deductibles and fees for noncovered services if the insured has been informed in advance that the service is not covered.

H.B. 2511 authorizes loans in the amount of $500,000 annually for four years from the Pooled Money Investment Board to an Uninsurable Health Insurance Plan Fund created by the legislation in order to assist with the start-up costs and expenses of the plan. Moneys loaned under this provision are required to be repaid over a ten-year period. Other provisions of the bill relate to audits and reports required to be made to the Joint Committee on Health Care Decisions for the 1990s.

Health Insurance Reform

(c) Other

Universal Claim Forms Required – Health Insurance

H.B. 2216, enacted in 1991, required the Insurance Commissioner to devise universal accident and sickness insurance claim forms which must be utilized by all insurance companies, HMOs, and nonprofit health care-related service corporations commencing not later than six months following notification by the Commissioner. Additional provisions clarify that insurers may not refuse to accept a claim filed on a uniform claim form but may accept a claim filed on any other form; and that insurers will not violate the uniform claim form law by using forms required by the federal government.

Uniform Electronic Data Exchange

S.B. 722, passed in 1992, amended the statute that was enacted by the 1991 Legislature that requires the Commissioner of Insurance to develop universal claim forms to be utilized by every insurer and, where applicable, HMO, offering any type of accident and sickness coverage for Kansas residents. The amendments require the Commissioner to report to the Governor and Legislature by the beginning of the 1993 Session on the development of uniform electronic data interchange formats and standards, along with a proposed plan, and an analysis of the cost impact.

Health Care – Indigent/Medical Assistance

Primary Care for the Medically Indigent

H.B. 2019, created in 1991 new statutory authority for three pilot programs to be operated through local health departments to determine the feasibility of providing primary care health services for the medically indigent and Medicaid and MediKan clients. The bill also amends several statutes in the Kansas Tort Claims Act and one statute that concerns the state program of financial assistance for local health departments.

The bill authorizes the allocation of state grant funds for the establishment and operation of three pilot programs conducted through local health departments chosen by the Secretary of Health and Environment from among local health departments applying for the grant funds. One of each of the pilot primary care programs must be located in a local health department or a consortium of local health departments that meets each of three population criteria set out in the bill. The local health agencies that receive grant funds are authorized: to contract with health care providers, community agencies, organizations, other public bodies, and private persons in order to provide primary care services; to define medically indigent for the purposes of the pilot program; to set fees based on the cost of services and established on a sliding scale based on ability to pay; to apply for financial assistance from governmental sources or the private sector; and to define primary care for the purposes of the pilot program. A health care provider who contracts with a local health department to provide professional services as a part of a pilot project is to be considered a charitable health care provider under the Kansas Tort Claims Act if such services are provided gratuitously or the provider is paid by the local health department.

One of the statutes in the existing laws that provide for the allocation of general state financial assistance to local health departments is amended by H.B. 2019 to make it clear that any one-time special project grant and moneys collected by local health departments from fees charged for services are not to be considered to be a part of the local tax revenues allotted to local health for the purpose of determining the state financial assistance to be distributed during the county fiscal year. Two statutes in the Kansas Tort Claims Act are amended to include health care professionals who provide services as part of a pilot program authorized by H.B. 2019 in the definition of "charitable health care provider" under that Act. The latter amendments have the effect of covering, under the Tort Claims Act, any professional liability that might be incurred through participation in a pilot program.

The provisions of H.B. 2019 relating to the creation of three pilot primary care programs expire on July 1, 1995.

Medicaid Managed Care Pilot

S.B. 119 created in 1993 a new law that directs the Secretary of Social and Rehabilitation Services, subject to applicable federal guidelines and regulations and to appropriations, to contract for a managed care pilot project to be conducted during fiscal year 1995 in Sedgwick County and another county having a population of less than 100,000 specified by the Secretary and a task force established pursuant to the provisions of the bill.

The new legislation directs that the pilot project be conducted to provide health services through a managed care system for Medicaid clients on the basis of a predetermined set of services to a predetermined population. In order to carry out the directives of the new legislation, the Secretary is authorized to contract with a single provider or a contracting agency, or both, to provide Medicaid services through a group of qualified health care providers within the areas specified as the pilot project. The Secretary is directed to appoint a task force or task forces to advise the Secretary on matters relating to the implementation of the pilot project and to make findings and recommendations concerning the pilot project that are to be reported to the Joint Committee on Health Care Decisions for the 1990s and to the Legislature on or before the beginning of the 1994 Session. The Secretary also is required to submit a preliminary report on the results of the pilot project to the Senate Committee on Ways and Means and the House Committee on Appropriations at the beginning of the 1994 Session and annually for the next four years.

Health Care Providers Serving the Poor – Liability

S.B. 736 extended coverage of the Kansas Tort Claims Act (KTCA) to health care providers providing charitable professional care services to medically indigent persons in 1990. As a precondition of coverage under the KTCA, a health care provider must have entered into an agreement with the Secretary of the Kansas Department of Health and Environment (KDHE) to provide gratuitous health care services to the medically indigent.

The Secretary is required to establish by rules and regulations criteria for determining whether a person qualifies as a medically indigent person. Medically indigent person is defined to mean a person who lacks resources to pay for medically necessary health care services and who meets the eligibility criteria established by the Secretary of KDHE.

Charitable Health Care Providers

S.B. 14 amends one of the statutes in the Kansas Healing Arts Act and three of the statutes that make up the Kansas Tort Claims Act as they relate to encouraging health care providers to provide charity care.

The Kansas Healing Arts Act is amended to make it clear that a license in the healing arts who holds an exempt license (a license issued to a person who has been licensed to practice the healing arts and who is no longer regularly engaged in such practice) may serve as a paid employee of either a local health department or an indigent care clinic without jeopardizing the exempt license status.

Amendments to the tort claims statutes expand the definition of "charitable health care provider" as that term is used in the Tort Claims Act. The term, charitable health care provider is expanded to include:

1. health care providers who enter into an agreement with the Secretary of Health and Environment and who, under such agreement, gratuitously render health care services to medically indigent persons or to persons receiving medical assistance under programs operated by the Secretary of Social and Rehabilitation Services (Medicaid or MediKan) and who are a health care provider considered an employee of the state under K.S.A. 1992 Supp. 75-6120;

2. health care providers who, under an agreement with the Secretary of Health and Environment, gratuitously render professional services in children's immunization programs administered by the Secretary; or

3. health care providers who have entered into an agreement with an indigent health care clinic or local health department which provides health care to medically indigent persons or persons receiving medical assistance under programs operated by the Secretary of Social and Rehabilitation Services to render health care services to the patients of such clinic or health department, regardless of whether the clinic or health department charges a fee for the services, if the health care provider is considered an employee of the state under K.S.A. 1992 Supp. 75-6120.

In the case of the health care provider who is considered a charitable health care provider under alternative 3 above, the provider is considered to be providing gratuitous services regardless of whether the health care provider is paid a fee by the local health department or indigent health care clinic.

Other amendments define terms used in the definition of charitable health care provider by adding definitions of "indigent health care clinic" and "local health department"; add professional services rendered in local health departments and indigent health care clinics and the employees thereof to the exemptions to the prohibition in the tort claims statutes against the payment of claims for health care provider professional liability from the Tort Claims Fund; and provide that payment may be made from the Tort Claims Fund rather than professional liability insurance to satisfy professional liability claims arising from the services provided by charitable health care providers who are considered employees of the state and by local health departments and indigent care clinics and the employees thereof for claims arising prior to July 1, 1995, or for claims in which the cause of action arose prior to July 1, 1995.

Amendatory language also requires the Legislature to conduct an annual review of claims and expenditures against the Tort Claims Fund arising from services provided by charitable health care providers, the number of charitable health care providers, and the extent to which coverage under the Tort Claims Fund has increased services to the medically indigent and those who are eligible for Medical Assistance. The provisions of the bill that concern the annual legislative review expire on July 1, 1995.

Health Care – Women and Children

Child Health Assessments

H.B. 2695 created a new act in 1992 under which, after July 1, 1993, all children entering a Kansas school for the first time will be required to present the results of a child health assessment that has been done within six months prior to school admission. As defined in the bill, health assessment means a basic screening for hearing, vision, dental, lead, urinalysis, hemoglobin-hemocrit, nutrition, developmental, health history, and complete physical examination. Health assessment results must be recorded on a form provided by the Secretary of Health and Environment and must have been conducted by a person licensed to practice medicine and surgery, or a licensed professional nurse or other health care provider approved by the Secretary of Health and Environment to do health assessments. Information contained in the health assessment is to be confidential and may not be disclosed or made public except as provided in the legislation. As an alternative to the health assessment required by the new legislation, a pupil may present a written statement signed by a parent or guardian that the child is an adherent of a religious denomination whose teachings are opposed to such assessments or a written statement that the health assessment is in the process of being done and will be completed within 90 days after admission to school. School boards may exclude children from school who have not complied with the law, must transfer records of compliance if the child transfers from one school to another, and must give pupils known to be enrolled or to be enrolling a copy of the applicable subsection of the legislation and the school's policy relating to implementation prior to the beginning of the school year.

H.B. 2695 requires any county, city-county, or multicounty health department, upon application of a school board, to provide a health assessment as required in the legislation to any child whose parent or guardian has not provided for such an assessment. Any assessments requested by a local school board must be conducted by the appropriate local health department, to the extent that funds are available for this purpose, at federal, state, county, municipal, local health department, or school district expense. The local health department may charge a fee based on ability to pay, except that no fee may be charged a pupil eligible for participation in a school lunch program. If no funds are available for the local health department to provide child health assessments, the local health department must certify to the school board that insufficient funds are available and, upon such certification, pupils who have been referred for the mandated assessment are to be exempt from the requirements of the law.

Child Health Assessments – Delay Thereof

1993 H.B. 2546 delayed the effective date of the mandate enacted in 1992 that requires, on and after July 1, 1993, any pupil entering a Kansas school for the first time to present the results of a health assessment recorded on a form provided by the Secretary of Health and Environment. The date on which health assessments are to be required is on or after July 1, 1994.

Infant-Toddler Program

H.B. 2759 created two new statutes in 1992 that concern the federally authorized early childhood intervention program that is most often referred to as the Infant-Toddler Program. An existing statute is amended by the bill.

Terms used in the new legislation are defined by H.B. 2759, including a definition of infants and toddlers with disabilities as children from birth through two years of age that are experiencing developmental delays or have a diagnosed mental or physical condition that has a high probability of resulting in developmental delay. Lead agency is defined as the Department of Health and Environment for purposes of the early intervention program. New authority is given to the Secretary of Health and Environment to adopt rules and regulations necessary to carry out agency responsibilities under P.L. 102-119, Part H, the Infant-Toddler Federal Grant Pilot Program section of the federal act. The bill amends K.S.A. 1991 Supp. 74-7802, the statute that sets out the duties of the Coordinating Council on Early Childhood Disabilities, to make the Council the agency responsible for advising and assisting the Department of Health and Environment in implementing P.L. 102-119, Part H, at the state and local level.

Immunizations – Children in Childcare

1992 H.B. 2694 amended K.S.A. 1991 Supp. 65-519 and K.S.A. 65-508, statutes that concern family day care homes and all other places in which children under age 16 are cared for outside their own homes by persons who are not related to such children by blood or marriage. The amendments provide that on or after January 1, 1993, each child cared for in a family day care home or other child care facility, including children of the provider of care, are required to have current immunizations determined by the Secretary of Health and Environment to be necessary. The registered family day care provider or licensed child care provider also is required to maintain a record of immunizations of children in care and to provide information thereon to the Secretary as required by rules and regulations adopted by the Secretary. H.B. 2694 provides for two exceptions to the immunization requirements, *i.e.*, when certification from a licensed physician is provided stating that the immunization would endanger the child's life or health or when a written statement signed by the child's parent or guardian is provided stating that the parent or guardian is an adherent of a religious denomination whose teachings are opposed to immunizations.

Immunizations

1993 S.B. 199 amended a statute that requires a child who is entering a Kansas school for the first time to present certification from a physician or local health department that such child has received or is in the process of receiving tests and inoculations as established by the Secretary of Health and Environment. The new language added to the statute by S.B. 199 extends the requirement to those children who are enrolling for the first time in a preschool or daycare program operated by a school.

Children and Families – Health Services for Pregnant Women and Children; Education and Services Relating to Perinatal Effects of Certain Substances; and Budget Information

S.B. 631 created a number of new laws that concern pregnant women, children, and families in 1992.

One of the new statutes created by the bill directs the Secretary of Health and Environment, on or before January 1, 1993, and working in cooperation with the Secretary of Social and Rehabilitation Services and the Commissioners of Insurance and Education, to develop a proposal for consolidating all existing health programs required by law for pregnant women and children into one comprehensive plan to be implemented by one or several agencies through interagency contracts, through contracts with private agencies, or by the provision of direct services. The plan developed pursuant to S.B. 631 is to include, at a minimum, comprehensive prenatal services for all pregnant women who qualify for existing programs; comprehensive medical care for all children under 18 years of age; preventative and restorative dental care for all children under 18 in a family that qualifies under the plan; periodic sight and hearing tests and corrective devices for children under 18; a case management system under which each family with a child under the plan is assigned a case manager and under which every reasonable effort is made to assure continuity of services and access to other appropriate social services. The plan developed pursuant to the new statute created by S.B. 631 is to be submitted to the Governor, the Joint Committee on Health Care Decisions for the 1990s, and the Kansas Commission on the Future of Health Care, Inc.

Seven new statutes that are created by S.B. 631 concern the identification of pregnant women at risk for substance abuse, the provision of services for such persons, and education as to the effects of the preconceptual and perinatal use of specified substances.

Under the seven new statutes, the Secretary of Health and Environment is directed to:

1. conduct an ongoing public awareness campaign directed at both men and women regarding the preconception and perinatal use of tobacco, alcohol, and controlled substances listed is Schedules I, II, and III of the Uniform Controlled Substances Act for nonmedical purposes;

2. provide educational materials and guidance to health care professionals that address the services available to pregnant women from local health departments and the perinatal effects of the use of certain substances;

3. in collaboration with the Secretary of Social and Rehabilitation Services, provide an educational program for health care professionals who provide care for pregnant women concerning patient education, taking drug histories, and counseling techniques;

4. develop a risk assessment profile to assist health care providers in screening pregnant women for prenatal substance abuse; and

5. maintain a toll free information line for the provision of information on resources for substance abuse treatment and for assisting with the referral of pregnant women.

Other provisions authorize any health care provider who identifies a pregnant woman at risk for prenatal substance abuse to refer such woman, with her consent, to a local health department or the Department of Health and Environment for service coordination by providing her name to the local agency or the Department of Health and Environment within five working days. Any referral and associated documentation is to be confidential and cannot be used in any criminal prosecution. The required consent for referral is to be deemed a waiver of the physician-patient privilege only for the purpose of making the referral. Any local health department receiving a referral from a health care provider is required to coordinate social services, health care, mental health services, and education

and rehabilitation services if needed. Service coordination must be initiated within 72 hours of the referral. Any pregnant woman referred for substance abuse treatment is to be a first priority for treatment available through Social and Rehabilitation Services, and all records regarding such woman are to be confidential. The Secretary of Social and Rehabilitation Services is required to ensure that family oriented substance abuse treatment is available, and substance abuse treatment facilities that receive public funds may not refuse to treat a pregnant woman solely because she is pregnant. The seven new statutes relating to perinatal substance use become effective on January 1, 1993.

S.B. 631 amends two statutes that concern the preparation of the annual Governor's Budget Report and repeals one such statute.

Amendments to K.S.A. 1991 Supp. 75-3717, in addition to technical amendments, require that each agency's budget estimates include a listing of all programs of the agency that provide services to children and their families, and specified information regarding each such program. In addition, the amendments define "services for children and their families" as that term is used in the statute to include financial support or the enforcement of support obligations; prenatal care, health care for children, or immunizations; mental health or mental retardation services for children; nutrition services for children or families with children, or nutritional counseling or supplements for pregnant or nursing women; child care, early childhood education, or parenting education; licensure or regulation of child care or early childhood education programs; treatment, counseling or other services to preserve families; care, treatment, placement, or adoption of children without functioning families; services to prevent child abuse and to treat and protect child abuse victims; services for children who are pregnant, substance abusers, or otherwise involved in high risk behavior; services relating to court proceedings involving children; and youth employment services.

New language added to K.S.A. 1991 Supp.75-3721 by S.B. 631 requires the Division of the Budget to compile a children's budget from information contained in agency budget estimates regarding programs that provide services for children and their families. The document developed by the Director of the Budget is to be provided to the Joint Committee on Children and Their Families; the Kansas Commission on Children, Youth and Families; and other persons or entities on request.

Other new provisions contained in S.B. 631 repeal K.S.A. 75-3721a, make it clear that nothing in the bill is to be construed to create any new programs, and make the provisions of the bill, except for the provisions relating to preconception and prenatal use of certain substances, effective on publication in the *Kansas Register*.

Kansas Healthy Kids Program Act

H.B. 2913 created a new act in 1992 under which a quasi-governmental corporation, to be known as the Kansas Healthy Kids Corporation, is directed to develop a health insurance program, based on ability to pay, for all Kansas school children in grades kindergarten through 12 and their siblings younger than age 18 who are not otherwise covered by public or private insurance programs. Under the provisions of the new legislation, the corporation is required to have the insurance benefits to be covered and the location of three pilot school districts established by July 1, 1993. Children are to be enrolled, and the corporation is to be providing insurance in at least three pilot school districts by July 1, 1994. The corporation also is required to provide for the expansion of the insurance program to other school districts. Insurance benefits offered under the program are exempt from the state provider and service mandates applicable to accident and health insurance.

The governing board of the corporation is directed to, among other responsibilities, establish the benefits to be offered through the insurance program; establish eligibility criteria; accept

and receive grants, loans, gifts, and donations; develop funding sources; and contract for the administration of any health insurance program initiated under the bill. The corporation also is directed to coordinate the program with other public and private initiatives and to report on its activities to the Governor and the Legislature. The corporation is given access to medical records of students with permission of the student's parent or guardian and subject to confidentiality requirements set out in the bill.

The Kansas Healthy Kids Corporation is to be governed by a 17-member, appointed board of directors assisted by the Secretaries of Social and Rehabilitation Services and Health and Environment and the Commissioners of Education and Insurance or their designees who are to serve as nonvoting members of the board. Appointed members of the board are to serve staggered four-year terms, except members of the Legislature who are to be appointed to terms that end on the first day of the regular legislative session held in odd-numbered years. Members of the board are to be paid subsistence, mileage, and expenses as authorized by subsection (e) of K.S.A. 75-3223, except the legislative members who are to receive compensation, subsistence, mileage, and other expenses as authorized for legislators. All officers and employees of the corporation are to be considered to be state employees and the corporation to be considered to be a state agency for payroll, deferred compensation, retirement, employment security, workers' compensation, health benefits, Social Security, and federal tax purposes. However, officers and employees of the corporation are not subject to the provisions of Article 32 of Chapter 75 of the Kansas statutes relating to compensation and expenses nor be a part of the state civil service system.

H.B. 2913 establishes a Healthy Kids Trust Fund in the state treasury to which are to be deposited all state appropriations, gifts, grants, contributions, matching funds, and payments made by program participants. All payments from the trust fund are to be made in accordance with appropriation acts and warrants issued pursuant to vouchers approved by the chairperson or such person's designee.

Health Care Provider

(a) Education

Kansas University Medical Center Medical Student Loan Program – Creation

Sub. for H.B. 2941 created in 1992 the Kansas University Medical Center (KUMC) Medical Student Loan Program. The program, subject to appropriations, will provide medical students the payment of all tuition and a stipend for living expenses in an amount of up to $1,500 per month for each month enrolled during a school year. The medical student receiving the loan must complete an approved postgraduate residency training program in general pediatrics, general internal medicine, family medicine, family practice, or emergency medicine. Within nine months after completion of an approved postgraduate residency training program the loan recipient must agree to practice medicine in any community within any county of Kansas other than Douglas, Johnson, Sedgwick, Shawnee, or Wyandotte counties. Other options for service include the practice of medicine at any state medical care facility or institution, any medical center operated by the Veterans Administration of the United States, or as a full-time faculty member of the University of Kansas School of Medicine in family practice or family medicine. For each year individuals receive loans they must practice medicine in an appropriate service commitment area or facility on a year for year basis. However, for those individuals who meet their service commitment on the faculty of

the University of Kansas School of Medicine, there is required two years of service for each year the loan is received.

The bill provides that the service commitment by a medical student loan recipient may be postponed for a period of up to five years because of active military service, service as a part of the Volunteers in Service to America (VISTA), service in the Peace Corps, service in the United States Public Health Service, or service as a religious missionary. In addition, the bill provides that a person may satisfy the obligation to engage in the full-time practice of medicine and surgery in a service commitment area by devoting at least 100 hours per month to a local health department or nonprofit organization serving medically indigent persons.

If medical student loan recipients enter a nonapproved postgraduate residency training program or if they do not enter the practice of medicine in an approved service commitment area they will be consider to be in noncompliance with the loan agreement. The recipients will have to repay KUMC the amount of moneys they received, plus 15 percent interest.

Kansas University Medical Center Medical Residency Bridging Program

H.B. 3211 established the Kansas Residency Bridging Program in 1992. The purpose of the program is to provide an incentive to medical residents in primary care training programs of the University of Kansas Medical Center (KUMC) or an affiliate of KUMC to commit to locating their medical practice, upon completion of training, in rural communities in Kansas. The program will be administered by the Institute for Rural Health Care of the University of Kansas School of Medicine.

Any individual is eligible for the program who has completed the first year of primary care residency training in general pediatrics, general internal medicine, family medicine or family practice, which is operated or affiliated with the University of Kansas School of Medicine and entered into between a medical resident and a city located in any county in the state other than Douglas, Johnson, Sedgwick, Shawnee, or Wyandotte. Under such an agreement the city must agree to pay the medical resident an amount equal to or greater than the amount paid by the Medical Center.

Under a residency bridging loan agreement the student would receive a payment of $5,000 from KUMC for each year of primary care residency training. Upon completion of the residency program, the resident would receive a $6,000 bonus payment. The agreement also would require that the individual complete the primary care residency training program, engage in the full-time practice of medicine and surgery in an eligible county for a period of three years, and start medical practice within 90 days after completing the residency training program. If any person who receives a loan fails to satisfy the agreement obligations, the individual must repay KUMC an amount equal to that received by the individual, less any credits earned, plus interest at an annual rate of 15 percent from the date the money was received.

Kansas Medical Residency Bridging Program

H.B. 2025 amended in 1993 the statute enacted in 1992 that created the Kansas Medical Residency Bridging Program under which medical residents in primary care who have completed the first year of a residency training program may enter into an agreement with any city in Kansas, except those located in specified counties, to practice medicine in the city upon completion of the residency in exchange for supplemental payments made during the remainder of the residency training by the University of Kansas Medical Center and the city and a bonus on completion of the residency program.

The amendments extend the residency bridging program to allow participation by residents in primary care programs in Kansas that are not affiliated with or operated by the University of Kansas School of Medicine, *i.e.*, osteopathic primary care residency programs operated in Kansas and approved by the Board of Healing Arts. Additionally, the amendments open the residency bridging program to permit residents to sign up for the program prior to entering into a practice commitment agreement with a city and to allow a person who graduated from the University of Kansas School of Medicine prior to July 1, 1992, and who has completed one year of a residency training program in family practice located outside of Kansas and entered into a practice commitment agreement with the North Central Kansas Health Care Foundation to be eligible to enter into a residency bridging loan agreement.

Medical Student Loan Program

1993 S.C.R. 1606 expresses the sense of the Legislature that increasing the number of primary care physicians in Kansas is an urgent issue and that it is the policy of the Legislature to support full funding and utilization of the Medical Student Loan Act and the 1992 legislation that created the medical residency bridging program through utilizing money available in the Medical Scholarship and Loan Repayment Fund. The specific policy enunciated by S.C.R. 1606 is that money in the Fund should be used solely to finance medical student loans, the bridging program, and two locum tenens positions to provide respite for rural primary care physicians. For FY 1994, the Legislature has recommended expenditures of $4,502,338 from the Medical Scholarship and Loan Repayment Fund, of which $2,802,338 is for medical loans (35 new and 94 renewals), $330,000 is for the Medical Residency Bridging Program, $276,000 is for the Faculty Locum Tenens Program, and $1,094,000 is for support of general operating expenditures in the KUMC-Education portion of the budget.

The 1992 Legislature created the KUMC Medial Student Loan Program to replace the Medical Scholarship Program. The new program, subject to appropriation, provides medical students the payment of all tuition and fees, and, in addition a stipend for living expenses up to $1,500 per month for each month enrolled during the school year. A medical student receiving a school loan must complete an approved postgraduate residency training program in general pediatrics, general internal medicine, family medicine, family practice, or emergency medicine. Within nine months after completion of an approved postgraduate residency training program the loan recipient must agree to practice medicine in any community within any county of Kansas other than Douglas, Johnson, Sedgwick, Shawnee, or Wyandotte counties. Other options for service include the practice of medicine at any state medical care facility or institution, any medical center operated by the Veterans Administration, or the University of Kansas School of Medicine as a full-time faculty member in family practice or family medicine.

In general for each year individuals receive loans they must practice medicine in an appropriate service commitment area or facility. If medical student loan recipients enter a nonapproved postgraduate residency training program or if they do not enter the practice of medicine in an approved service commitment area they will be considered to be in noncompliance with the loan agreement. The recipients will have to repay the amount of the loan they received, plus 15 percent interest. Repayments to the old medical scholarship program and new medical loan program are credited to the Medical Scholarship and Loan Repayment Fund.

The 1993 Legislature appropriated funding to provide 45 new loans in FY 1993 and 35 new loans in FY 1994. The loans for FY 1993 are retroactive to the beginning of the academic year.

Faculty Locum Tenens Program

The Legislature appropriated in 1993 $276,000 to initiate a Faculty Locum Tenens Program at KUMC. The program is intended to provide the equivalent of two full-time faculty members (one located at the Kansas City campus in the Family Practice Department and the other to be located at the Wichita campus in the Family Practice Department) to provide temporary relief for solo practitioners in rural Kansas who are not able to serve the community due to illness, a need for vacation, continuing medical education, or a variety of other reasons. Rural primary care physicians cite the lack of relief as a significant deterrent to establishing and maintaining a rural practice. According to KUMC, the program will be designed so that the locum tenens physicians would assume practice responsibilities in those communities where patient care is seriously compromised when the community physician must be away. Revenue for the program would also be generated from a combination of patient charges, contractual payments from the community physician, or both. KUMC is expected to report to the 1994 Legislature a full description of the program, an accounting of the program's activities in FY 1994, including the amount of time actually spent out in relief in rural communities.

Collaborative Nurse Practitioner Program

The Legislature appropriated $400,000 from the State General Fund in 1993 and added 11.0 FTE positions for nurse practitioners programs offered collaboratively by Kansas University Medical Center, Wichita State University, and Fort Hays State University. In addition to the State General Fund appropriation, the Kansas Health Foundation awarded the collaborative project a grant which provides approximately $475,000 annually for FY 1994 and FY 1995. The collaborative program includes several classes via interactive video.

Kansas University Medical Center Contracting Authority

The omnibus appropriation bill (1993 Sub. S.B. 437) also included a subsection authorizing expenditures from the Hospital Revenue Fund, upon recommendation of the Chancellor and approval of the State Board of Regents, for the University Hospital to enter into contracts for purposes of affiliations, partnerships, and equity ownerships with other health care providers. Such contracts are not subject to the competitive bid requirements. Contracts shall not be made for acquisition of equipment, supplies, materials, or other goods. KUMC is required to make a quarterly report to the Legislative Coordinating Council, the Chairpersons of Senate Ways and Means and House Appropriations, and the Secretary of Administration on all such contracts and expenditures made pursuant to this subsection.

Kansas University Medical Center Managed Care Contracts

The omnibus appropriation bill (Sub. S.B. 437) includes a subsection permitting KUMC to contract with the Kansas State Employees Health Care Commission to provide health care services to state employees through a managed care system. Such contract is not subject to the competitive bid requirements.

Also, in addition to the implementation of two managed care pilot projects for the medical program envisioned by 1993 S.B. 119, the Conference Committee on the SRS budget agreed to recommend a third pilot project at the University of Kansas Medical Center. These projects would not be operational until FY 1995.

Kansas University Medical Center Management Study

The 1993 Legislature appropriated $100,000 ($50,000 from the EDIF and $50,000 from the KUMC Hospital Revenue Fund) to the Kansas Board of Regents for a comprehensive management study of KUMC.

Kansas University Medical Center Integrated Computer System

The 1993 Legislature appropriated $350,000 from the EDIF in FY 1994 for the state's share of an integrated computer system to be used by the University Hospital and the private practice foundations for billing, scheduling, etc. The funding is subject to approval by the State Finance Council and is contingent upon the University and private practice foundations providing the remaining two-thirds of the total cost of the project. Also, the Joint Committee on Computer and Telecommunications is required to review the proposal and advise the State Finance Council.

Service-Based Student Scholarship Programs – Amendments

H.B. 2026 amended in 1992 the law relating to the Osteopathic Scholarship Program, Nursing Scholarship Program, and Optometry Education Program.

The bill amends the Osteopathic Scholarship Program to: increase the maximum award from $10,000 to $15,000; change the practice obligation requirement for all recipients of scholarships after June 30, 1992 to provide that recipients may fulfill their obligation by practicing primary care in any county, except Douglas, Johnson, Sedgwick, Shawnee, or Wyandotte counties; and alter the requirements for fulfilling a service obligation to permit a student to pursue a residency training program in a nonprimary care specialty prior to fulfilling the service obligation.

The bill amends the Nursing Scholarship Program to establish two additional funds, Nursing Student Scholarship Discontinued Attendance Fund and Nursing Student Scholarship Repayment Fund.

Also, the bill amends the Optometry Education Program to create an Optometry Education Repayment Fund.

Advanced Registered Nurse Practitioner Scholarship Program

1993 S.B. 17 creates the Advanced Registered Nurse Practitioner Scholarship Program under which not more than 12 new state funded scholarships may be offered annually to nurses enrolled in post-basic education and training programs leading to certificates of qualification to practice as advanced registered nurse practitioners (ARNPs) in the specialties of nurse clinician or nurse practitioner or clinical nurse specialist. The scholarship program is to be administered by the State Board of Regents and to be available to applicants who agree to enroll as full-time students in an advanced training and education program and who meet other qualifications set out in the bill.

Under the provisions of S.B. 17, scholarships awarded under the act may not exceed $15,000 annually and are conditioned on the recipient entering into an agreement to engage in full-time practice or equivalent practice as provided in rules and regulations of the administrative agency in a rural area or a medically underserved area of Kansas on the basis of one year of practice for each year the scholarship assistance was awarded. Failure to satisfy the terms of the agreement entered into between the nurse and the Board of Regents would result in an obligation to repay the

state an amount representing the total amount of money received by the scholarship recipient plus annual interest of 15 percent.

S.B. 17 creates the Advanced Registered Nurse Practitioner Student Scholarship Program Fund in the State Treasury and provides that all monies deposited to the Fund are to be used for scholarships awarded pursuant to the provisions of the bill.

The State Board of Regents is authorized by S.B. 17, after consultation with the Nursing Scholarship Review Committee created under K.S.A. 74-3299, to adopt rules and regulations as set out in the new legislation.

Health Care Provider

(b) Other

Healing Arts Referrals – Notice Required

S.B. 19 amended in 1993 K.S.A. 65-2837, one of the statutes that makes up the Kansas Healing Arts Act, to add to the list of actions that constitute unprofessional conduct on the part of a licensee in the healing arts. Pursuant to the new provisions, a healing arts licensee who refers a patient to a health care entity in which the licensee has a significant investment interest without informing the patient in writing of such interest and that the patient may obtain services elsewhere would be engaging in unprofessional conduct and be subject to disciplinary action by the Board of Healing Arts.

For the purposes of the new provision, "health care entity" means any corporation, firm, partnership, or other business entity which provides services for diagnosis or treatment of human health conditions and which is owned separately from a referring licensee's principle practice. The term "significant investment interest" is defined for the purposes of the new provision to mean ownership of at least 10 percent of the value of the firm, partnership, or other business entity which owns or leases the health care entity, or ownership of at least 10 percent of the shares of stock of the corporation which owns or leases the health care entity.

Ambulatory Surgical Centers

S.B. 402 amended in 1993 the statute that defines terms used in the act under which medical care facilities are licensed and regulated. The amendment changes the definition of "ambulatory surgical center," a facility that, under prior law, is an establishment with an organized staff of physicians and permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, that does not provide services or other accommodations for a patient to stay overnight. The amendments define an ambulatory surgical center as an establishment with an organized medical staff of one or more physicians that does not provide services or accommodations for a patient for more than 24 hours. In addition, the amendments change the requirement relating to the availability of physician services in an ambulatory surgical center. The new definition requires only that physician services be available on site during surgical procedures and until the patient has recovered from the obvious effects of an anesthetic. At other times physician services are required to be available whenever a patient is in the facility,

and each patient is required to be evaluated by a physician for proper anesthesia recovery prior to discharge. New language added to the definition makes it clear that physician's offices are not required to be licensed as ambulatory surgical centers.

S.B. 402 defines the term "physician" for the purposes of the entire act under which medical care facilities are licensed and regulated to mean a person licensed to practice medicine and surgery.

Rural Health

Rural Health

Sub. for H.B. 2710 created in 1992 a new act that recognizes in Kansas law concepts embodied in federal legislation authorizing incentives to encourage the organization of rural health resources into rural health networks. The bill states the policy of the State of Kansas as encouraging the development of and participation in rural health networks. The latter term is generally defined as an alliance of members including at least one rural primary care hospital (RPCH) and one essential access community hospital (EACH) or supporting hospital that has developed an approved comprehensive plan regarding patient referral and transfer, the provision of emergency and nonemergency transportation among members, a network-wide emergency services plan, and a plan for sharing patient information and services between hospital members concerning medical staff credentialing, risk management, quality assurance, and peer review.

The seven new statutes created by Sub. for H.B. 2710 define new terms used in the legislation; provide for the licensing of rural primary care hospitals and the designation of essential access community hospitals; authorize members of rural health networks (hospitals, emergency medical services, local health departments, home health agencies, mental health centers or clinics, medical clinics, or nonemergency transportation systems) or the rural health network to enter into agreements for the performance of services with any other person or entity; allow rural primary care hospitals, essential access community hospitals, and rural health networks to employ health care providers to provide patient care and services and providers or other persons to carry out the functions of the network; authorize the Secretary of Health and Environment to set minimum standards for the establishment and operation of rural health networks; and provide that accident and sickness insurance policies, HMO contracts, and other health benefits plans must cover services provided in rural primary care hospitals, essential access community hospitals, and supporting hospitals if such services would be covered if provided in a general hospital. Other provisions of the legislation make it clear that members of a rural health network are acting pursuant to state policy and under state supervision in forming an integrated network and contracting for services and are not subject to state or federal antitrust laws when acting in compliance with the authorization of the state.

Sub. for H.B. 2710 also amends one of the statutes in the act under which hospitals are licensed and regulated to add a definition of rural primary care hospital and to provide that hospitals may be licensed as such. Amendments to K.S.A. 1991 Supp. 65-4909 add mid-level practitioners as defined in the new legislation and respiratory therapists to the statutes relating to the liability of organizations for actions arising from peer review.

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