Approved: 3-10-95
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 20, 1995 in Room 526-S of the Capitol.

All members were present except:

Committee staff present:
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Melissa Hungerford, Kansas Hospital Association
Elizabeth W. Saadi, Office of Health Care Information, KDHE
Jerry Slaughter, Executive Director, Kansas Medical Society
Charlene Satzler, Center for Health and Environmental Statistics, KDHE
Andrew R. Pelletier, M.D., Bureau of Disease Control, KDHE

Others attending: See attached list

Hearing on: SB 293 - Health care data governing board to collect and make information available to the public of established charges for services of health care providers

Senator Doug Walker testified before the Committee in regard to **SB 293** and called attention to Recommendation No. 43 of 1990 Governor's Commission on Health Care that would require providers to make price information available to consumers of health care. He noted that **SB 293** would implement that recommendation and suggested an amendment to the bill that would require the Health Care Data Governing Board report to the legislature by February 1, 1996 and annually thereafter on the progress they have made in providing to the legislature and to consumers the information outlined in K.S.A. 65-6801. Such change would give specific direction to the board and set a deadline for action. Material from Pennsylvania Health Care Cost Containment Council was also included with his written testimony. (Attachment 1) During Committee discussion Senator Walker noted that if price information were made available to the consumer, it would put pressure on insurance companies and entities such as HMOs to ensure that hospitals would do an efficient job and doctors maintain good ratings. It was also pointed out that the Health Care Data Governing Board would determine what information to collect and how to compile that information in order for it to be useful to the consumer.

Melissa Hungerford, KHA, appeared before the Committee and noted that the bill is redundant to both the current data governing board statutes related to the authority given to the data board. She also noted that information from the Pennsylvania Health Care Cost Containment Council provided by Senator Walker would be very useful to the consumer, and that she would like to see the suggested language change proposed by Senator Walker before supporting the bill. (Attachment 2)

Elizabeth W. Saadi, KDHE, appeared before the Committee and noted they are not in support of the bill as written. Ms. Saadi commented they would like to have the Committee and legislature give the Data Board more guidance as to what kind of data is needed. (Attachment 3) During Committee discussion it was noted that the data base KDHE is working on for the Department of Insurance would be made available to the Data Board. The Chair also suggested an interim study could be made on targeting specific functions of the Board.

Jerry Slaughter, KMS, addressed the Committee and noted that the Data Board has worked hard to meet the requirements in the statutes and would like to see Senator Walker's suggested amendment before supporting the bill. (Attachment 4)

Written testimony was also submitted by Harold E. Riehm, Executive Director, Kansas Association of Osteopathic Medicine. (Attachment 5)

Hearing on: SB 308 - Release of death information

Charlene Satzler, KDHE, testified in support of **SB 308** as noted in her written testimony. (Attachment 6)

There were no opponents to the bill.

Action on SB 308

Senator Walker made a motion the Committee recommend **SB 308** favorably for passage and the bill be placed on the consent calendar, seconded by Senator Langworthy. The motion carried.

Hearing on SB 309 - Prenatal tests for Hepatitis B

Andrew R. Pelletier, M.D., KDHE, testified in support of **SB 309** as noted in his written testimony. (Attachment 7) During Committee discussion Dr. Pelletier noted that the cost of a test for Hepatitis B is $8.00 for the state as opposed to $15 for a private test.

There were no opponents to the bill.

Action on SB 309

Senator Langworthy made a motion the Committee recommend **SB 309** favorably for passage, seconded by Senator Hardenburger. The motion carried.

Hearing on SB 335 - Disclosure of vital records information

Charlene M. Satzler, KDHE, testified in support of **SB 335** and noted that the new language was omitted in the bill and submitted a balloon copy of the bill with the proposed language. (Attachment 8)

Action on SB 335

Senator Lee made a motion the Committee adopt the balloon amendment of the bill, seconded by Senator Langworthy. The motion carried.

Senator Lee made a motion the Committee recommend **SB 335 as amended** favorably for passage, seconded by Senator Langworthy. The motion carried.

The meeting was adjourned at 10:45 a.m.

The next meeting is scheduled for February 21, 1995.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-20-95

NAME	REPRESENTING
Martin Hawver	Hawver's Capitol Report
HAROLD PITTS	KCOA
Chip Wheelen	KS Medical Soc
Michelle Peterson	Ks Gov. Consulting
GARY Robbins	Ks Optometric Assn
Tom Bell	Ks. Hosp. Assn.
Harold Richm	KAOM
Melissa Hungerford	Ks Hosp Assn
Larry Buening	Bd of Healing Arts
Mark Stafford	
Charlene Seifers	Health & Env.
Lou Sgadi	KDHE
[illegible]	KNS
Andrew Allen	KDHE
Gianfranco Pessino	KDHE
Jennifer Calder	KDHE
Roger Fravel	Ks Gov. Consulting

STATE OF KANSAS

DOUG WALKER
SENATOR, 12TH DISTRICT
ANDERSON, BOURBON, FRANKLIN,
LINN, MIAMI COUNTIES

TOPEKA

SENATE CHAMBER

OFFICE OF DEMOCRATIC WHIP

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER
EDUCATION
PUBLIC HEALTH AND WELFARE
MEMBER: ENERGY AND NATURAL RESOURCES
FEDERAL AND STATE AFFAIRS
HEALTH CARE DECISIONS FOR THE '90s

TESTIMONY ON SB 293

In 1990, Governor Hayden by executive order created the Governor's Commission on Health Care to review and make recommendations on improving the Kansas health care system. After extensively reviewing reports from past commissions and the then-current status of health care, the commission made 46 different recommendations. All of its recommendations were designed to incrementally improve the market based health care system. Recommendation number 43 reads: " Require providers to make price information available to consumers of health care."

SB 293 is a bill which would implement that recommendation. In the absence of any major health care reform coming from either the federal or state level, it is important for the current health care environment that we help people become better and smarter consumers of health care services.

I have attached to my testimony a copy of the 1993 enabling legislation for the Health Care Data Governing Board. As you can see from the highlighted text, statutory provisions already exist to fulfill the intent of SB 293.

I am suggesting that we amend SB 293 to require the Health Care Data Governing Board to report to the legislature by February 1, 1996 and annually thereafter on the progress they have made in providing to the legislature and to consumers the information outlined in K.S.A. 65-6801. This change simply gives specific direction to the board and sets a deadline for action.

212 FIRST STREET
OSAWATOMIE, KANSAS 66064
913-755-4192

Senate Public Health & Welfare
Date: 2-20-95
Attachment No. 1

CASE ANNOTATIONS

1. Kansas residency not required for unemancipated pregnant minor to seek waiver of parental notification. In re Doe, 17 K.A.2d 567, 843 P.2d 735 (1992).

Article 68.—HEALTH CARE DATA

65-6801. Health care database; legislative intent; use of information. (a) The legislature recognizes the urgent need to provide health care consumers, third-party payors, providers and health care planners with information regarding the trends in use and cost of health care services in this state for improved decision-making. This is to be accomplished by compiling a uniform set of data and establishing mechanisms through which the data will be disseminated.

(b) It is the intent of the legislature to require that the information necessary for a review and comparison of utilization patterns, cost, quality and quantity of health care services be supplied to the health care database by all medical care facilities as defined by subsection (h) of K.S.A. 65-425, and amendments thereto, and all other health care providers to the extent required by K.S.A. 1993 Supp. 65-6805 and amendments thereto.

(c) The information is to be compiled and made available in a form prescribed by the governing board to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services.

History: L. 1993, ch. 174, § 1; July 1.

65-6802. Same; request for and use of data by department of health services administration of university of Kansas. (a) The department of health services administration of the university of Kansas and any institute or center established in association with the department is hereby authorized to request data for the purposes of conducting research, policy analysis and preparation of reports describing the performance of the health care delivery system from public, private and quasi-public entities.

(b) The department of health services administration of the university of Kansas may request data for purposes of conducting research, policy analysis and preparation of reports describing the performance of the health care delivery system from any quasi-public or private entity which has such data as deemed necessary by the department.

History: L. 1993, ch. 174, § 2; July 1.

65-6803. Same; health care data governing board created; appointment of task force or task forces; meetings and duties of the board. (a) There is hereby created a health care data governing board.

(b) The board shall consist of seven members appointed as follows: One member shall be appointed by the Kansas medical society, one member shall be appointed by the Kansas hospital association, one member shall be appointed by the executive vice chancellor of the university of Kansas school of medicine, one member representing health care insurers or other commercial payors shall be appointed by the governor, one member representing adult care homes shall be appointed by the governor, one member representing the institute associated with the university of Kansas department of health services administration and one member representing consumers of health care shall be appointed by the governor. The secretary of health and environment, or the designee of the secretary, shall be a nonvoting member who shall serve as chairperson of the board. The secretary of social and rehabilitation services and the insurance commissioner, or their designees, shall be nonvoting members of the board. Board members and task force members shall not be paid compensation, subsistence allowances, mileage or other expenses as otherwise may be authorized by law for attending meetings, or subcommittee meetings, of the board. The members appointed to the board shall serve for three-year terms, or until their successors are appointed and qualified.

(c) The chairperson of the health care data governing board may appoint a task force or task forces of interested citizens and providers of health care for the purpose of studying technical issues relating to the collection of health care data. At least one member of the health care data governing board shall be a member of any task force appointed under this subsection.

(d) The board shall meet at least quarterly and at such other times deemed necessary by the chairperson.

(e) The board shall develop policy regarding the collection of health care data and procedures for ensuring the confidentiality and security of these data.

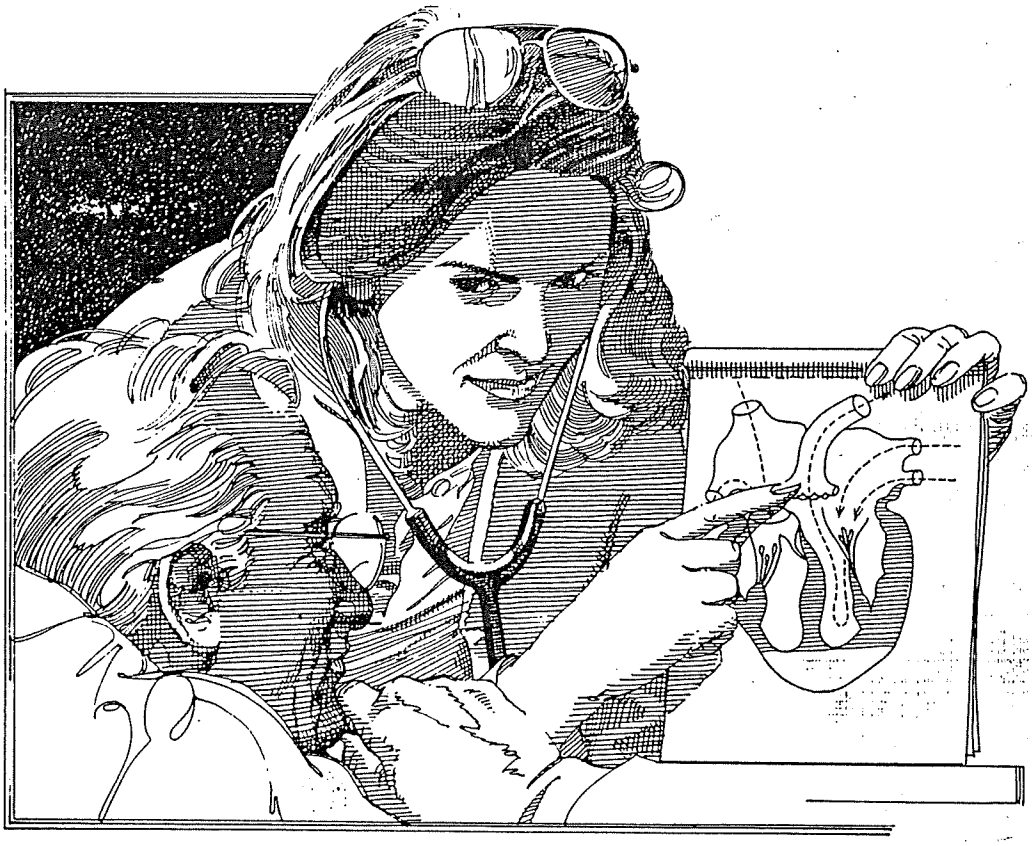
History: L. 1993, ch. 174, § 3; July 1.

65-6804. Same; duties of secretary of health and environment; contract for data collection; rules and regulations. (a) The secretary

1-2

A Consumer Guide to

Coronary Artery Bypass Graft Surgery



PENNSYLVANIA HEALTH CARE
COST CONTAINMENT COUNCIL

ACT 89

Pennsylvania's Declaration of Health Care Information

Foreword

The Pennsylvania Health Care Cost Containment Council has prepared this booklet for people considering coronary artery bypass graft surgery. Ask your doctor questions about the information in it. If you have questions that aren't covered in this booklet, again, ask your doctor. You may also wish to discuss the contents of this booklet with your hospital representative and the insurance benefits person where you are employed.

The Pennsylvania Health Care Cost Containment Council is an independent state agency responsible for addressing the cost and quality of health care in Pennsylvania. The Council promotes health care competition through the collection, analysis, and public distribution of uniform cost and quality health care information.

In the mid-1980's, the major interest groups in Pennsylvania which were involved in health care financing became increasingly concerned about the rising cost of health care. Businesses were devoting an increasing portion of their resources to costly health benefits for their employees. Labor union members were struggling, often going on strike, to prevent the erosion of valued health care benefits. Health care providers were concerned that payments for services were not covering their costs. The Commonwealth also recognized that health care costs were consuming a staggering portion of the state's annual budget. These same groups were also concerned that efforts to contain costs should not undermine access to health care in Pennsylvania.

The combined support of these groups, as well as insurers and consumers, encouraged the Pennsylvania General Assembly to pass Act 89 in 1986 which created the Health Care Cost Containment Council. This report is the latest in a series of reports designed to assist the public in making more informed health care choices.

A technical report with a detailed explanation of the research methods used to prepare this information may be obtained by contacting the Council office at the address listed below. In addition, hospitals and physicians may have elected to comment on the information presented in this booklet. A free copy of those comments may also be obtained by contacting the Council office.

Pennsylvania Health Care Cost Containment Council
Harrisburg Transportation Center
Harrisburg, PA 17101
(717) 232-6787

Table of Contents

Introduction

About 68 million Americans have some form of heart-related disease. It is the leading cause of death in the United States. This booklet is designed to provide consumers with information on the surgical procedure used to treat one type of heart disease known as atherosclerotic coronary artery disease.

This booklet will help you make comparisons among hospitals and cardiac surgeons should you require surgical treatment for coronary artery disease. It can also help you know which questions to ask your doctor, and to make a more informed choice when selecting a hospital or surgeon for coronary artery bypass graft surgery (CABG). Please use this information in conjunction with your doctor and hospital.

The information is based on reports from the 35 of the 36 Pennsylvania hospitals certified to perform coronary artery bypass graft surgery during 1990. (Conemaugh Valley Memorial Hospital did not perform enough procedures in 1990 to be included in this report, since their coronary bypass surgical unit just opened that year.)

The charts show the average charge and the number of CABG surgery patient deaths for each hospital in Pennsylvania where at least 30 coronary bypass operations were performed. The charts also show the number of CABG surgery patient deaths for each cardiac surgeon who performed at least 30 coronary bypass operations. Thirty is considered a minimum number in order for the information to be statistically meaningful.

What is athersclerotic coronary artery disease?

Atherosclerotic coronary artery disease occurs when the arteries which supply blood to the heart muscle become lined with fatty deposits, harden, and become partially blocked. The amount of blood reaching the heart is reduced. This reduced flow of blood can cause chest pain (angina), or a heart attack.

What is cardiac catheterization?

Cardiac catheterization is a diagnostic test procedure performed with the aid of x-rays to identify blockages or narrowed areas in the heart vessels. This test helps determine if coronary artery bypass graft surgery is needed. A long, thin tube called a catheter is inserted into a blood vessel in the arm or groin and threaded into the coronary arteries. Dye is injected through the catheter, and x-rays of the vessels are taken.

What methods are used to treat heart disease?

It is important to discuss this with your physician. Depending on a patient's condition and the doctor's recommendation, the following are among treatment methods that might be used: changes in lifestyle habits such as diet or smoking, medication, balloon angioplasty, laser angioplasty, and coronary artery bypass graft surgery. This report deals with coronary artery bypass graft operations, which are performed by a cardiac surgeon. However, when seeking treatment for heart disease, a physician known as the cardiologist is usually involved in the diagnosis of heart disease. In general, it is the cardiologist who will diagnose the problem, and refer the patient to a cardiac surgeon if surgery is being considered or recommended. This report can be used in conjunction with the advice of your cardiologist in selecting a cardiac surgeon.

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"HOW TO READ THE CHARTS"

This chart is presented as a guide to help readers understand information in the charts. Please note that these are not actual data, but used for reference purposes only.

Hospitals Performing Coronary Artery Bypass Graft Surgery

Treatment Effectiveness & Average Charge

1 Hospital	2 Total Patients	Patients Who Died: 3 Actual Number	4 Expected Range	5 Statistical Rating	6 Average Charge (In dollars)
7 *Hospitals With Fewer Number of Deaths Than Expected*					
Hospital A	150	8	8.44 - 12.23	+	$59,438
8 *Hospitals With Similar Number of Deaths as Expected*					
Hospital G	276	9	6.21 - 9.20	Δ	$39,946
9 *Hospitals With Greater Number of Deaths Than Expected*					
Hospital M	508	31	18.67 - 28.15	–	$44,789

1. Name of hospital where surgery was performed.

2. Actual number of patients treated at the hospital in 1990 for coronary bypass surgery.

3. Actual number of patients admitted to the hospital for coronary bypass surgery, who died.

4. The expected range of patient deaths at the hospital, taking into account the age, sex, and medical condition of that hospital's patients.

5. Compares the actual number of patient deaths to the statistically expected number of patient deaths for that hospital:

   \+ hospital had significantly fewer deaths than expected;

   – hospital had significantly more deaths than expected;

   Δ the hospital's number of patient deaths was not significantly different than expected.

6. The average amount billed for the stay in the hospital for coronary bypass surgery.

7. Hospitals with significantly fewer deaths than expected (plus symbol) are grouped together in this table.

8. Hospitals with similar numbers of deaths as expected (triangle symbol) are grouped together.

9. Hospitals with greater number of deaths than expected (minus symbol) are grouped together.

Hospitals Performing Coronary Artery Bypass Graft Surgery

Treatment Effectiveness & Average Charge

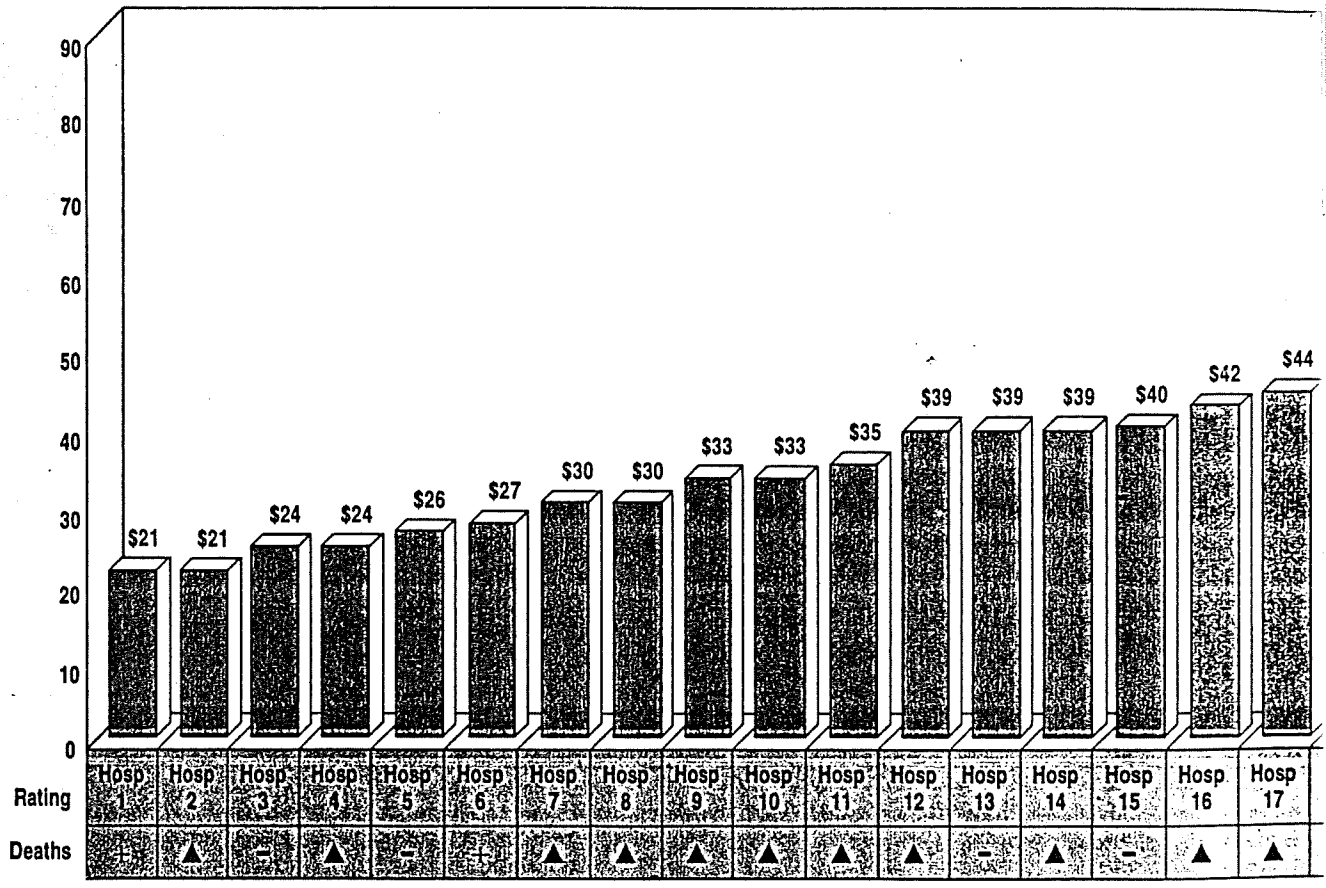
Hospital	Total Patients	Patients Who Died			Average Charge (In dollars)
		Actual Number	Expected Range	Statistical Rating	
Hospitals with Fewer Number of Deaths than Expected					
Allegheny General Hospital	1,010	25	29.32 - 52.60	+	$46,704
Altoona Hospital	332	4	5.35 - 18.08	+	$27,333
Hahnemann University Hospital	847	26	29.44 - 53.49	+	$65,825
Reading Hospital and Medical Center	526	12	15.99 - 33.76	+	$21,063
Hospitals With Similar Number of Deaths as Expected					
Albert Einstein Medical Center	581	23	20.85 - 41.08	Δ	$61,971
Bryn Mawr Hospital	300	15	5.63 - 17.69	Δ	$49,309
Central Medical Center & Hospital	335	14	8.45 - 23.18	Δ	$46,544
Episcopal Hospital	285	18	8.05 - 21.64	Δ	$44,081
Geisinger Medical Center /Danville	323	15	3.91 - 15.30	Δ	$30,202
Hamot Medical Center	444	16	6.21 - 19.82	Δ	$34,769
Lancaster General Hospital	673	17	13.75 - 31.79	Δ	$24,307
Lankenau Hospital	584	25	15.57 - 33.74	Δ	$48,261
Medical College Hospitals /Main Clinical Campus	174	7	1.61 - 10.73	Δ	$56,530
Mercy Hospital of Pittsburgh	682	20	17.62 - 36.42	Δ	$39,002
Montefiore University Hospital	204	11	1.67 - 11.23	Δ	$54,479
Pennsylvania Hospital	90	1	0.72 - 7.79	Δ	$51,164
Polyclinic Medical Center	330	8	2.28 - 12.75	Δ	$39,314
Presbyterian Medical Center of Philadelphia	478	14	13.58 - 30.74	Δ	$42,408
Presbyterian-University Hospital	171	6	2.37 - 12.59	Δ	$70,089
Robert Packer Hospital	386	10	5.04 - 17.96	Δ	$21,246
Saint Luke's Hospital of Bethlehem	337	14	7.84 - 21.67	Δ	$33,245
Saint Vincent Health Center	304	11	4.10 - 16.25	Δ	$45,667
Shadyside Hospital	714	23	22.07 - 42.50	Δ	$56,015
Temple University Hospital	258	20	8.12 - 22.44	Δ	$65,303
Thomas Jefferson University Hospital	292	14	6.45 - 19.05	Δ	$52,464
University Hospital Milton S. Hershey Medical	201	6	3.27 - 13.44	Δ	$33,282
Western Pennsylvania Hospital	579	10	9.29 - 24.87	Δ	$57,569
Wilkes-Barre General Hospital	214	4	2.32 - 12.23	Δ	$29,746
Hospitals With Greater Number of Deaths Than Expected					
Graduate Hospital	287	20	4.71 - 17.00	–	$83,851
Harrisburg Hospital	467	21	6.42 - 20.09	–	$39,587
Hospital of the University of Pennsylvania	354	33	8.50 - 22.38	–	$76,928
Lehigh Valley Hospital	920	46	20.67 - 40.69	–	$39,186
Mercy Hospital /Scranton	415	27	7.90 - 21.79	–	$23,885
Saint Francis Medical Center	463	31	13.26 - 29.03	–	$48,808
York Hospital	335	13	2.23 - 11.96	–	$26,334
STATEWIDE TOTAL	14,895	580			$44,649

Hospitals and Physicians may have commented on this report. Copies are available upon request.
Source: Pennsylvania Health Care Cost Containment Council, 1990 data.

Chart of Hos
Charges and

Coronary Artery B

Listed Lowest to



Hospital Key

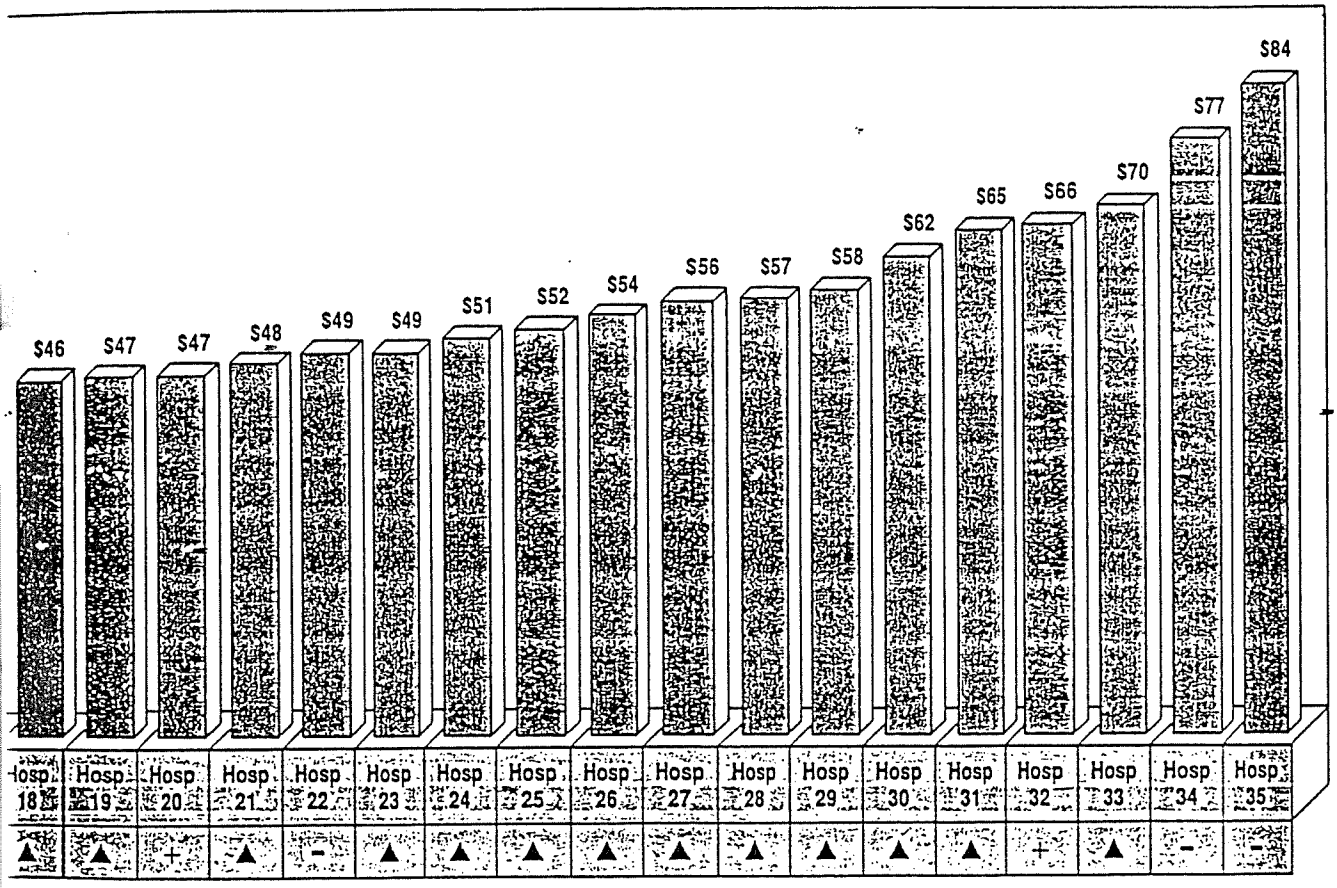
1 Reading Hospital and Medical Center
2 Robert Packer Hospital
3 Mercy Hospital/Scranton
4 Lancaster General Hospital
5 York Hospital
6 Altoona Hospital
7 Wilkes-Barre General Hospital
8 Geisinger Medical Center/Danville
9 Saint Luke's Hospital of Bethlehem
10 University Hospital Milton S. Hershey Medical Center
11 Hamot Medical Center
12 Mercy Hospital of Pittsburgh
13 Lehigh Valley Hospital
14 Polyclinic Medical Center
15 Harrisburg Hospital
16 Presbyterian Medical Center of Philadelphia
17 Episcopal Hospital
18 Saint Vincent Health Center

1-9

ɔitaı Average
Patient Deaths

ypass Graft Surgery

ighest by Charge



19 Central Medical Center & Hospital
20 Allegheny General Hospital
21 Lankenau Hospital
22 Saint Francis Medical Center
23 Bryn Mawr Hospital
24 Pennsylvania Hospital
25 Thomas Jefferson University Hospital
26 Montefiore University Hospital
27 Shadyside Hospital
28 Medical College Hospitals/Main Clinical Campus
29 Western Pennsylvania Hospital
30 Albert Einstein Medical Center
31 Temple University Hospital
32 Hahnemann University Hospital
33 Presbyterian-University Hospital
34 Hospital of the University of Pennsylvania
35 Graduate Hospital

Statistical Rating Key

+ fewer deaths than expected

▲ same as/similar to expected

- more deaths than expected

1-10

"HOW TO READ THE CHARTS"

This chart is presented as a guide to help readers understand information in the charts.
Please note that these are not actual data, but used for reference purposes only.

Western Pennsylvania Area Hospitals
Physician Practice Groups and Cardiac Surgeons
for Coronary Artery Bypass Graft Surgery

Treatment Effectiveness Measure

5 Hospital Physician Practice Group *and* Surgeons	1 Total Patients	Patients Who Died		
		2 Actual Number	3 Expected Range	4 Statistical Rating
6 HOSPITAL NAME	367	14	11.25 - 18.62	Δ
7 Practice Group Name	203	8	6.91 - 9.73	Δ
8 Physician 1 *	190	6	6.20 - 8.64	Δ
Physician 2	13	*less than 30 patients treated*		
9 Solo Practitioner Name	164	6	5.69 - 7.23	Δ

1. Actual number of patients treated by the hospital, practice group, and individual physician in 1990 with coronary bypass surgery. The number of patients treated by each individual physician is listed next to their name.

2. Actual number of patients treated with coronary bypass surgery, who died during hospitalization.

3. The expected number of patient deaths for the hospital, practice group, and individual physician taking into account the age, sex, and condition of that practice group's patients.

4. Compares the actual number of patient deaths to the statistically expected number of patient deaths for that hospital, practice group or individual physician:

   \+ significantly fewer deaths than expected;

   – significantly more deaths than expected;

   Δ the actual number of patient deaths was not significantly different than expected.

5. The physician information is grouped first by one of three geographic areas in Pennsylvania (example: Western Pennsylvania area). Secondly by hospital name, then practice group name (or physician name if surgeon is a solo practitioner). The physicians within a practice group are listed alphabetically, under the practice group name.

6. Name of the hospital in which the following practice groups and individual physicians performed surgery.

7. Name of the physician practice group responsible for the surgery, followed by the individual surgeons who belong to the practice group.

8. Individual surgeons who belong to the practice group. An asterisk means this physician performed surgery at more than one hospital.

9. Individual surgeons practicing alone - not in a group.

1-11

Western Pennsylvania Area Hospitals
Physician Practice Groups and Cardiac Surgeons for Coronary Artery Bypass Graft Surgery

Treatment Effectiveness Measure

Hospital Physician Practice Group *and* Surgeons	Total Patients	Patients Who Died		
		Actual Number	Expected Range	Statistical Rating
ALLEGHENY GENERAL HOSPITAL	1,010	25	29.32 - 52.60	+
Cardio-Thoracic Surgical Assoc., Inc.	1,004	24	29.05 - 52.23	+
Benckart, Daniel H. *	153	2	1.45 - 10.76	Δ
Burkholder, John A. *	121	2	1.72 - 10.01	Δ
Liebler, George A. *	146	5	0.76 - 8.92	Δ
Magovern, George J. Jr. *	147	4	1.55 - 10.30	Δ
Magovern, George J. Sr.	18	*less than 30 patients treated*		
Magovern, James A.	133	4	1.34 - 10.31	Δ
Maher, Thomas D. *	151	5	1.94 - 10.99	Δ
Park, Sang B. *	135	2	1.26 - 9.58	Δ
McCabe, John S., MD	6	*less than 30 patients treated*		
CENTRAL MEDICAL CENTER & HOSPITAL	335	14	8.45 - 23.18	Δ
Three Rivers Cardiac Institute	335	14	8.45 - 23.18	Δ
Darrell, John C. *	72	1	0.00 - 6.60	Δ
DiMarco, Ross F. *	14	*less than 30 patients treated*		
DiPaola, Douglas J. *	81	3	0.57 - 8.15	Δ
Grant, Kathleen J. *	53	1	0.00 - 4.45	Δ
Pellegrini, Ronald V. *	23	*less than 30 patients treated*		
Woelfel, George Frederick *	92	5	0.77 - 8.61	Δ
HAMOT MEDICAL CENTER	444	16	6.21 - 19.82	Δ
D'Angelo Clinic	413	10	5.62 - 18.79	Δ
D'Angelo, George J.	149	4	0.29 - 7.99	Δ
Kish, George F.	57	0	0.00 - 3.95	Δ
Marshall, William Gene Jr.	58	2	0.00 - 4.36	Δ
Sardesai, Prabhaker G.	55	1	0.00 - 4.12	Δ
Tan, Wilfredo S.	94	3	0.00 - 6.40	Δ
Hanson & Associates, Inc.	31	6	0.00 - 2.58	–
Hanson, Elbert Lawrence	15	*less than 30 patients treated*		
Kerth, William J.	16	*less than 30 patients treated*		

Statistical Rating Key
+ fewer deaths than expected
– more deaths than expected
Δ the number of deaths was not different than expected

* *This surgeon has privileges at another hospital and some of his/her patients are listed under that hospital. Refer to the tables on pages 8 through 15 to identify these hospitals.*

Hospitals and Physicians may have commented on this report. Copies are available upon request.

1-12

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

February 20, 1995

TO: Senate Public Health & Welfare Committee

FROM: Melissa Hungerford
Senior Vice President

RE: **Senate Bill No. SB-293, Public Information On Health Provider Charges**

Thank you for the opportunity to provide our reasons for opposition of Senate Bill 293 that establishes a new set of data on Health Provider Charges and directs that these data be published in a reference book for public distribution. KHA does not oppose making these data public. Rather, we question the need for this legislation for three basic reasons.

1. Senate Bill 293 is redundant to both the current data governing board statutes related to the authority given to the data board (KSA 65-6805). It is also a redundant data base to that being developed pursuant to Senate Bill 487 passed in the 1994 session. The statistical plan developed for this legislation calls for the collection of specific data that will meet the needs of Senate Bill 293.

2. We suggest that you consider this as a policy and resource priority issue. To develop and collect data and produce this reference book is an extremely costly process. Most likely, all of the data governing board's budget and staff will necessarily be redirected to this project. Is a buyers guide the highest priority for the use of scarce resources? We would suggest that data are more critical to determine effects of the changing environment on the system. Will consolidation leave gaps in available services? Will heavily managed care decrease quality and results while it is decreasing costs? If the committee feels a buyers guide is a higher priority, it should make that clear to the Chair of the Data Board.

3. Our final reason for opposing Senate Bill 293 is an issue of relevance. Charges do not reflect payments or costs of the system. Managed care directs patients to specific providers and establishes what will be paid. Those folks who are negotiating these rates have access to these data now.

It is for these reasons that we believe new legislation is not necessary. The bottom line - Senate Bill 293 will have a significant fiscal note and does not produce the data necessary to support the priority issues that Kansas needs to consider.

Senate Public Health & Welfare
Date: 2-20-95
Attachment No. 2

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 2

State of Kansas

Bill Graves  Governor

Department of Health and Environment

James J. O'Connell, Secretary

Testimony presented to
Senate Public Health and Welfare
by
The Kansas Department of Health and Environment
Senate Bill 293

I am pleased for the opportunity to provide comments on Senate Bill 293. The Kansas Department of Health and Environment is not in support of this bill.

The requirements of this bill to collect data from numerous health care providers, compiling these data and publishing an annual document is much more complex that one might think. From the agency's practical point of view, the information gathering proposed in this bill would be cumbersome to manage with surveys anticipated to be sent to over 6,000 physicians, several thousand other health professionals named in the bill, over 350 mental health centers and 160 hospitals. The volume of data generated by this bill is enormous. Charges could be collected for the vast number of procedures such as over 900 inpatient procedure codes and thousands of outpatient procedure codes. Even the charge itself would be nebulous, since we must decide then if we want to collect negotiated prices with carriers or plans. In light of some of these issues, the survey instrument itself becomes complex for someone to complete. Finally, once charge figures have been collected, they would change before the information can be published.

When the legislature gave KDHE the authority to develop a health care database in 1993, the Health Care Data Governing Board was also created to assist the agency in developing policies and procedures for creating the database. One of its first recommendations was to exhaust the information in existing databases before developing new ones. To be consistent with this recommendation and obtain these data, insurance carriers could be requested to provide this information. In 1994, the legislature passed SB 487 which required the Kansas Insurance Department to implement a statistical plan for accident and health insurance and designated KDHE to be its statistical agent. This database is still in the planning stages but once it is functional, it will make data such as these mentioned today available for analyses. Data related to billed charges and paid amounts are maintained by health insurance carriers and this would be a centralized source of information that could be obtained and published without burdening specific health care providers. Data such as reasonable and customary charges or even average charges for services could be computed and made available in a document.

Since the evaluation of cost of health care services is one of the kinds of products that will be made available through the health care database, we welcome any direction given by the legislature to further identify for the Board the information they would like to see distributed to the public about the finances of health care. We would request that in regard to SB 293, the Health Care Data Governing Board's recommendations be considered, not burden providers and utilize existing data sources for the health financial information.

Testimony presented by: Elizabeth W. Saadi, Ph.D., Director
Office of Health Care Information
February 20, 1995

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Senate Public Health & Welfare
Date: 2-20-95
Attachment No. 3

KANSAS MEDICAL SOCIETY
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February 20, 1995

TO: Senate Public Health & Welfare Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 293; Concerning reports by health care providers to the Health Care Data Governing Board

The Kansas Medical Society appreciates the opportunity to appear today as you consider SB 293, which would require a long list of health care providers to make annual reports on their charges to the Health Care Data Governing Board. We cannot support this legislation.

There are several reasons for our opposition to SB 293, and formost among them is that the information to be gathered in such an exercise will be essentially meaningless in the health care delivery system which is emerging. As the entire marketplace moves to approved networks of providers who deliver services at negotiated fees, or under capitation payment arrangements, individual charge information has no meaning. In capitated systems, for example, network providers agree to a flat fee per month for each of their patients, and no individual fees are charged. Even in non-capitated systems where providers make charges for services, virtually every payor utilizes a fixed fee schedule with pre-set copayments and deductibles, so the patient (consumer) knows exactly what any out of pocket costs will be in advance. In such systems providers are prohibited from "balance billing," or charging the patient more than the amount allowed in the fee schedule.

Even in today's system, which is in a period of transition from fee for service to capitation dominated delivery models, the information sought in SB 293 is of marginal value. There are virtually no insurance companies or managed care plans that pay physicians what they *charge*, unless that charge is less than or equal to the *allowed* amount in the plan's fee schedule. Again, the individual charge information bears no relevance to what is actually paid, since the health plan establishes in advance, for its covered patients, a schedule of allowed fees from the approved network of providers it contracts with.

Senate Public Health & Welfare
Date: 2-20-95
Attachment No. 4

One must ask what value is there to be derived from collecting charge information from health care providers. We can find little, if any, to the consumer of health services. For the providers, however, there will be considerable cost, hassle and time involved. A typical physician's practice may utilize hundreds, or in the case of a multi-specialty clinic, thousands of individually coded services that all have specific fees assigned to them. While some may be used quite infrequently, they nevertheless would have to be reported. We believe that physicians time is better spent taking care of patients, not processing more paperwork.

Another point is worth mentioning. The Health Care Data Governing Board represents an opportunity for the state to begin gathering meaningful data to assist legislators, researchers and others in the process of asking and answering the *right* questions about the health system. Those questions, we believe, have more to do with how the health needs of the population are being met in terms of access, system design, distribution of providers and services. By requiring the Data Board to apply its resources on *charge* data, when the entire system is moving towards different systems, seems to be focusing on the past, instead of the future. We believe the Data Board has established a good platform of cooperation among health care providers, and should be allowed to concentrate on gathering information which will help answer the most pressing questions on where our system should *go*, not where it has *been*. We urge you to report SB 293 unfavorably. Thank you for the opportunity to offer these comments.

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

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February 20, 1995

To: Chairperson Praeger and Members, Senate Public Health Committee

From: Harold E. Riehm, Executive Director, KAOM

Subject: Observations on SB 293

KAOM has serious reservations about the policy that would be put in place by SB 293, collection of data and publication of extablished charges of health care providers, by the Health Care Data Governing Board.

From the physician perspective we make these observations:

a. In many respects the physician as lost control of the "pricing mechanism" in charging for his or her services. These are increasingly dictated by Medicare, Medicaid, and third party carriers. This trend will accelerate as Kansas become more under the influence of managed care instittutions.

b. Physicians often have a variety of charges, again dictated by external forces. Which is to be collected and published?

c. While physicians are sensitive to the critical nature of their charges to the overall health care milieu, we question whether health care providers should be singeled out for publications of charges. Is this not valid for other professions too?

d. The physician community has been a willing and cooperative partner to the efforts of the Legislature and the Health Care Date Board in collecting and disseminating some health sensitive data. Whether or not support can be retained were it extended to collection and dissemination of prices charged, is an unanswewable question at this point in time. We think it would place in question the proper role of the Data Collection process.

Thank for this opportunity to express our views.

Senate Public Health & Welfare
Date: 2-20-95
Attachment No. 5

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

Testimony presented to
Committee on Public Health and Welfare
by
The Kansas Department of Health and Environment

Senate Bill 308

S.B. 308 would allow the Office of Vital Statistics to release **fact of death only** information to federal and state benefit paying programs to ensure benefits are not being paid erroneously to deceased individuals.

The Office of Vital Statistics currently has a contract and receives funds from Social Security Administration to provide fact of death information. However, in August, 1993 a provision was included in the Budget Reconciliation Act that prohibits the disclosure of federal tax returns or return information to states that do not enter into a contract allowing SSA to **re-release** this information to other federal programs to ensure federal benefits are not being paid erroneously to deceased individuals.

The proposed legislation would allow the OVS to release fact of death information to state and federal agencies administering benefit programs provided the information was to be used for file clearance purposes and file clearance purposes only. As stated above, failure to release such information may negatively impact federal/state cooperative efforts and could cost the state considerable revenue.

We see no negative ramifications of such action, but in fact see release of fact of death information as having a positive impact on benefit paying programs at both the state and federal level which in turn will result in a cost savings to the taxpayer.

As some of you may recall, this same provision was proposed during the 1994 legislative session as part of S.B. 547; however, it was tied to release of birth certificate information and did not pass.

Since KDHE does not have any benefit-paying programs, the proposed legislation would not directly impact KDHE; however, SRS, KPERS, Department of Human Resources, Department of Revenue and other benefit paying agencies would be impacted.

Testimony presented by: Charlene Satzler, Director
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February 20, 1995

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State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

Testimony presented to

Senate Committee on Public Health and Welfare

by

The Kansas Department of Health and Environment

Senate Bill No. 309

Senate Bill No. 309 proposes to require that pregnant women in Kansas be screened during prenatal care for infection with hepatitis B virus. Approximately 1% of the United States population is chronically infected with hepatitis B. If untreated at the time of birth, 90% of children born to mothers with hepatitis B become infected. About one-quarter of these children will eventually die from complications of hepatitis B. The appropriate use of hepatitis B vaccine and immune globulin can prevent most all of these infections. In order to identify which newborns need to be protected at birth, all pregnant women should be screened during prenatal care. Results of a study done in 1992 indicated that 84% of pregnant women in Kansas are currently being screened for hepatitis B. The federal Centers for Disease Control and Prevention suggests that state laws requiring prenatal screening for hepatitis B are an effective method for increasing screening rates closer to 100%. Prenatal screening for hepatitis B is also recommended by the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, and the American Academy of Family Practice.

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February 20, 1995

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CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

May 6, 1994 / Vol. 43 / No.17

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Maternal Hepatitis B Screening Practices — California, Connecticut, Kansas, and United States, 1992–1993

Each year in the United States, an estimated 22,000 infants are born to women with chronic hepatitis B virus (HBV) infection. These infants are at high risk for perinatal HBV infection and chronic liver disease as adults. The American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the American Academy of Family Practice, and the Advisory Committee on Immunization Practices each have recommended that all pregnant women be routinely tested for hepatitis B surface antigen (HBsAg) during an early prenatal visit in each pregnancy to identify newborns who require immunoprophylaxis for the prevention of perinatal HBV infection (*1–4*). To evaluate progress in implementing this recommendation, surveys were conducted to assess the effectiveness of maternal HBsAg screening in three states—California, Connecticut, and Kansas—and a sample of hospitals in the United States.

California

Since 1991, universal prenatal HBsAg screening and reporting have been required by law in California. In January 1993, the California Department of Health Services (CDHS) assessed prenatal HBsAg screening and reporting of pregnant women with chronic HBV infection in Merced and Stanislaus counties. CDHS personnel reviewed the medical records of 994 (97%) of the 1027 births that occurred in the seven hospitals with obstetric services in those two counties during September 1992. Charts of each mother and her infant were reviewed for documentation of maternal HBsAg screening.

Documentation of maternal HBsAg screening was present for 979 (98%) women, of whom 10 (1%) were HBsAg-positive. All 10 HBsAg-positive women had been reported to CDHS, and all infants received hepatitis B immune globulin (HBIG) and hepatitis B vaccine at birth.

Connecticut

To evaluate the perinatal hepatitis B prevention program in Connecticut, a systematic sample of women who delivered during January 1–February 15, 1993, was selected from the birth log of each of the seven hospitals with obstetric services in Bridgeport, Hartford, and New Haven; 80 women were selected from each hospital. Charts of each mother and her infant were reviewed for written evidence of maternal HBsAG screening results, the number and provider source of prenatal-care visits, and selected risk factors for prior HBV infection (e.g., drug use and country of birth). Of the 560 selected births, charts were available and reviewed for 538 (96%) mothers, 529 (94%) infants, and 515 (92%) mother-infant pairs.

Documentation of maternal HBsAg screening was present in 484 (90%) maternal records (range by hospital: 86%–99%), 344 (65%) infant charts, and 112 (29%) of the 385 infant discharge summaries included in the infants' charts. Women without evidence of prenatal care were more likely to have no screening results (26%) than those with evidence of prenatal care (8%) (Table 1). Of 533 mothers for whom residence was known, those who resided outside of the three cities were more likely to lack screening results (12%) than city residents (6%) (Table 1). Lack of screening was not associated with source of prenatal health care or maternal risk factors for prior HBV infection.

Kansas

To determine maternal HBsAg screening practices of physicians in Kansas, birth certificates were obtained for 454 (74%) of 613 newborns randomly selected from 3984 state public health laboratory reports on screening for metabolic diseases for infants born during May 1992. A questionnaire was mailed to the 210 physicians responsible for the 454 deliveries; 204 (97%) physicians responded and returned questionnaires with usable data for 412 births.

Of the 412 mothers, 346 (84% [95% confidence interval=80%–88%]) had been screened for HBsAg. White women were more likely to lack screening results than women of races other than white (Table 1). Maternal factors not associated with lack of prenatal HBsAg screening included age, gravidity, level of education, timing of initial prenatal visit, and number of prenatal visits. Women cared for by family or general practitioners were more likely to lack screening results than women receiving care from obstetricians (Table 1). Physician factors not associated with prenatal HBsAg screening practices included age and board certification.

Hepatitis B — Continued

United States

In 1993, a random sample of 183 hospitals with obstetric services from the 1992 member list of the American Hospital Association were surveyed to evaluate hospital policies for maternal HBsAg screening, determine the prevalence of screening on a sample of births, identify risk factors for lack of screening, and determine the

TABLE 1. Characteristics associated with lack of maternal hepatitis B surface antigen screening — Connecticut, Kansas, and United States, 1992–1993

		Not screened			
Area/Characteristic	Total	No.	(%)	Relative risk	(95% CI*)
CONNECTICUT (n=538)					
Prenatal care					
No†	61	16	(26)	3.4	(2.0– 5.7)
Yes	477	37	(8)	Referent	(1.2– 4.2)
City resident§					
No	335	41	(12)	2.2	(1.2– 4.2)
Yes	198	11	(6)	Referent	
KANSAS (n=412)					
Race					
White	374	65	(17)	6.6	(0.9–46.5)
Other¶	38	1	(3)	Referent	
Obstetric provider**					
Family/General practitioner	98	35	(36)	3.5	(2.3– 5.4)
Obstetrician	307	31	(10)	Referent	
UNITED STATES (n=3982)					
Hospital Policy					
No policy	998	384	(39)	6.6	(5.4– 8.2)
Nonwritten	1364	162	(12)	2.1	(1.6– 2.6)
Written	1620	94	(6)	Referent	
State law requiring screening					
No	2945	553	(19)	2.2	(1.8– 2.8)
Yes	1037	87	(8)	Referent	
Infant's medical-care provider					
Family practitioner	1166	259	(22)	1.7	(1.5– 2.0)
Other	344	63	(18)	1.4	(1.1– 1.8)
Pediatrician	2472	318	(13)	Referent	
Hospital location					
Rural	1536	305	(20)	1.5	(1.3– 1.7)
Urban	2446	335	(14)	Referent	

*Confidence interval.
†No mention in mother's chart.
§Information for five women is unknown.
¶Includes blacks, American Indians/Alaskan Natives, and Asians/Pacific Islanders.
**Information for seven women is unknown.

Hepatitis B — Continued

treatment given to infants of HBsAg-positive women. Medical records of 3982 infants were reviewed to identify written evidence of maternal HBsAg screening; if information was missing from the infant's record, maternal records were reviewed.

Overall, 138 (75%) hospitals had policies that maternal HBsAg screening be done before or at the time of all deliveries; 70 (51%) of these hospitals had written policies. Of the 50 hospitals located in states with laws requiring maternal HBsAg screening, 27 (54%) had written policies to screen all pregnant women. In contrast, of the 133 hospitals located in states without such laws, 32% had screening policies ($p<0.05$).

Maternal HBsAg screening results were identified for 84% of infants and were present on 60% of infant's medical records. HBsAg results were present more often in the medical records of infants born in hospitals with policies requiring maternal screening compared with hospitals that had no such policies and in states with screening laws compared with states without such laws (Table 1). Other factors associated with lack of maternal HBsAg screening results included specialty of the infant's medical-care provider and birth in a rural hospital (Table 1).

Among 3342 women who had HBsAg screening, 12 (0.4%) had chronic HBV infection. Of the 12 infants born to these women, eight received hepatitis B vaccine and HBIG at birth, two received hepatitis B vaccine alone, and two received no treatment to prevent perinatal HBV transmission.

Reported by: L Burd, M Chiang, GW Rutherford, III, MD, State Epidemiologist, California Dept of Health Svcs. A Banaie, S Dutta, M Faruqi, C Ho, A Richman, K Riester, C Rohr, H Yusuf, Yale Univ Dept of Epidemiology and Public Health; A Roome, JL Hadler, MD, State Epidemiologist, Connecticut Dept of Public Health and Addiction Svcs. R Carlson, PhD, W Craft, C Keeling, L Phillips, PhD, R Ryan, PhD, C Satzler, J Schmid, M Ummel, A Pelletier, MD, Acting State Epidemiologist, Kansas Dept of Health and Environment. Div of Field Epidemiology, Epidemiology Program Office; Epidemiology and Surveillance Div, National Immunization Program; Hepatitis Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: The findings in this report indicate that, although maternal HBsAg screening is well integrated into routine prenatal care, screening of pregnant women and reporting of results to health-care providers is not complete in many geographic areas. In addition, these surveys suggest that perinatal screening of mothers who, on admission, do not have screening results is not consistently practiced. The prevalence of chronic HBV infection is higher among women who have not been screened or who have not received prenatal care (*5*). The failure to document maternal screening results in the delivery room record has been associated with inadequate immunoprophylaxis of infants born to HBsAg-positive women (*6*). When maternal HBsAg status is unknown at the time of delivery, infants should receive the dose of hepatitis B vaccine recommended for infants born to HBsAg-positive women within 12 hours of birth and the recommended second and third dose at ages 1 month and 6 months (*2*). To ensure appropriate follow-up of all infants and linkage of the hospital records with those of well-child care providers, HBsAg status should be documented on infants' discharge summaries or vaccination records. In addition, infants born to HBsAg-positive mothers should be reported to the local health department to ensure they are tracked and receive all three doses of hepatitis B vaccine.

Universal screening and treatment of exposed infants have not been achieved for at least three reasons. First, providers may be unaware of the effects of perinatal HBV infections because newborns with HBV infection are usually asymptomatic and the adverse outcomes (e.g., chronic hepatitis, cirrhosis, and hepatocellular carcinoma) oc-

Hepatitis B — Continued

cur when they are adults. Second, laws requiring maternal HBsAg screening have been enacted in only nine states, and the national survey suggests that state laws improve HBsAg screening practices. Third, some practitioners may be selectively screening patients based on the Advisory Committee on Immunization Practices recommendations made in 1984; selective screening of pregnant women for HBsAg based on race/ethnicity or other risk group criteria listed in those recommendations can miss a substantial proportion of HBsAg-positive women (*7,8*).

Although routine infant hepatitis B vaccination is recommended in the United States, prevention of perinatal HBV transmission requires sustained efforts to screen pregnant women for HBsAg. The findings in this report suggest several strategies for assisting in the prevention of perinatal HBV transmission. Educational efforts for health-care providers in rural areas and for primary-care providers should emphasize the importance of screening all women for HBsAg. Hospitals should develop policies to ensure that all women are screened for HBsAg before delivery, perinatal screening is conducted for women without previous HBsAg screening results, and infants born to HBsAg-positive women receive appropriate medical treatment and are reported to the local health department. In addition, hospital policies should ensure that maternal screening results are documented in the infants' medical records and conveyed to well-child care providers. Finally, legislators should be provided information that could be used in drafting laws requiring HBsAg screening of all pregnant women.

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State of Kansas

Bill Graves Governor

Department of Health and Environment
James J. O'Connell, Secretary

Testimony presented to
Senate Committee on Public Health and Welfare
by
The Kansas Department of Health and Environment

Senate Bill 335

In reviewing the drafted bill, we note that the new language was omitted. Therefore, I am presenting to you a balloon copy of the bill including the proposed language and then will address the proposal as set out in the balloon.

The proposed language in the balloon of S.B. 335 would remove marriage and divorce records from those vital records restricted by confidentiality statutes. In other words, they would become open records.

Currently marriage and divorce records are open records at the county level, but are restricted by statute at the state level. This proposal would make release of marriage and divorce records consistent at both the state and county level.

It is difficult for the customer to understand why we cannot release a record to them at the state level, yet we tell them they can access the same record at the county level. This becomes even more frustrating when the customer finds they cannot access the record they desire simply because they do not know in which county the event occurred knowing that we have all records on file and accessible without knowing the specific county of event.

This proposal would provide the customers with better service without compromising the confidentiality of records since these records are already open records at the county level. In addition, the number of applications processed would increase somewhat which in turn would generate more fees for the general fund.

There would be no negative fiscal impact; rather the fiscal impact would be an increase in fees generated. We would not project the increase to be significant.

Testimony presented by: Charlene M. Satzler, Director
Office of Vital Statistics
February 20, 1995

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SENATE BILL No. 335

By Committee on Public Health and Welfare

2-15

AN ACT concerning disclosure of vital record information; amending K.S.A. 65-2422d and repealing the existing section; also repealing K.S.A. 65-2422.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-2422d is hereby amended to read as follows: 65-2422d. (a) The records and files of the ~~division of health~~ *department of health and environment* pertaining to vital statistics shall be open to inspection, subject to the provisions of this act and rules and regulations of the secretary. It shall be unlawful for any officer or employee of the state to disclose data contained in vital statistical records, except as authorized by this act and the secretary, and it shall be unlawful for anyone who possesses, stores or in any way handles vital statistics records under contract with the state to disclose any data contained in the records, except as authorized by law.

(b) No information concerning the birth of a child shall be disclosed in a manner that enables determination that the child was born out of wedlock, except upon order of a court in a case where the information is necessary for the determination of personal or property rights and then only for that purpose.

(c) The state registrar shall not permit inspection of the records or issue a certified copy of a certificate or part thereof unless the state registrar is satisfied the applicant therefor has a direct interest in the matter recorded and the information contained in the record is necessary for the determination of personal or property rights. The state registrar's decision shall be subject, however, to review by the secretary or by a court in accordance with the act for judicial review and civil enforcement of agency actions, subject to the limitations of this section.

(d) The secretary shall permit the use of data contained in vital statistical records for research purposes only, but no identifying use of them shall be made.

(e) Subject to the provisions of this section the secretary may direct the state registrar to release birth, death and stillbirth certificate data to federal, state or municipal agencies.

(f) On or before the 20th day of each month, the state registrar shall

furnish to the county election officer of each county, without charge, a list of deceased residents of the county who were at least 18 years of age and for whom death certificates have been filed in the office of the state registrar during the preceding calendar month. The list shall include the name, age or date of birth, address and date of death of each of the deceased persons and shall be used solely by the election officer for the purpose of correcting records of their offices.

(g) No person shall prepare or issue any certificate which purports to be an original, certified copy or copy of a certificate of birth, death or fetal death, except as authorized in this act or rules and regulations adopted under this act.

(h) Records of births, deaths or marriages which are not in the custody of the secretary of health and environment and which were created before July 1, 1911, pursuant to chapter 129 of the 1885 Session Laws of Kansas, and any copies of such records, shall be open to inspection by any person and the provisions of this section shall not apply to such records.

(i) Social security numbers furnished pursuant to K.S.A. 65-2409 and amendments thereto shall only be used as permitted by title IV-D of the federal social security act and amendments thereto or as permitted by section 7(a) of the federal privacy act of 1974 and amendments thereto. The secretary shall make social security numbers furnished pursuant to K.S.A. 65-2409 and amendments thereto available to the department of social and rehabilitation services for purposes permitted under title IV-D of the federal social security act.

Sec. 2. K.S.A. 65-2422 and 65-2422d are hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

(j) Marriage and divorce records shall be open records and not subject to the provisions of this section.