Approved: March 4, 1996
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Bill Bryant at 3:30 p.m. on February 21, 1996 in Room 527S-of the Capitol.

All members were present except: Representative Tom Sawyer
Representative Phill Kline

Committee staff present: Bill Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Gary Haulmark, Kansas Psychological Association
Dr. David Hill, Psychologist
Dr. H. Darby Trotter, Psychologist
Joe Furjanic, Kansas Chiropractic Association
Jerry Slaughter, Kansas Medical Society
Taylor Markle, D.D.S.
Bob Williams, Kansas Pharmacists Association
Debbie Folkerts, ARNP, FNP
Carole Gates, Kansas Managed Health Care Association
James P. Schwartz, Jr., Kansas Employer Coalition on Health
Bill Sneed, Health Insurance Association of America
Terry Leatherman, Kansas Industrial Council
Brad Smoot, Blue Cross/Blue Shield
Dr. Bruce Barter, Humana
John Smith, Division of Vehicles

Others attending: See attached list

Hearing on HB 2985 - Accident and sickness insurance, providing for out-of-network access

Gary Haulmark, representing the Kansas Psychological Association, announced the point of service providers who were sponsoring this bill (Attachment 1).

David O. Hill, Ph.D., a licensed psychologist from Prairie Village, spoke on behalf of freedom of choice in health care (Attachment 2). Health care costs have spiraled in large part because health care in Kansas and the rest of the country has evolved into the most advanced and effective system in the world. Advances in diagnosis, treatment, and prevention have occurred because our health care system has provided for basic and clinical research; improved access to care; and patient choice in selecting providers. Limiting the scope and provider panel can lead to a disruption of treatment especially in the mental health arena. Patients should be allowed to opt out of any closed system to seek needed services. Quality assurance is lacking in the largely unregulated managed care industry. A point of service guarantee serves as a quality assurance check by allowing patients to seek care from specialists outside the network. These out of network providers would be paid at the rate of the network provider with the patient paying the balance as a copayment. The legislation would allow for up to 70% of the out of network provider's fee to be paid by the HMO, thus being no additional cost to the health plan.

H. Darby Trotter, Ph.D., practicing clinical and consulting psychologist in Prairie Village, explained the history and over-zealous development of managed care which was due to the popular but high cost fee for service system (Attachment 3). The managed care systems are now being questioned regarding quality of treatment, accessibility, portability, elimination of pre-existing condition clauses, and extended health benefits. Cost control concepts endorsed by nearly all managed care systems were listed as:

1. Limited benefit plans.
2. Exclusion of coverage for pre-existing conditions.
3. Pre-certification prior to treatment.

4. Authority to determine what is a medical necessity, i.e., how much treatment is approved for a particular illness.
5. Conservative lifetime limits.
6. Limited choice of doctors.
7. Financial incentives to the doctor who does not make referrals to specialists.
8. Financial incentives to the doctor who does not order extensive medical testing.
9. Gag rules to prevent doctors from discussing treatment options with patients.

The proposed legislation would expand opportunities for treatment and choice of providers so people can get the best quality of help available, even if they must pay more to be able to exercise the right of freedom of choice.

Joe Furjanic, Executive Director of the Kansas Chiropractic Association, spoke in support of the bill which is equitable to the patient, the out of network provider, and the network itself (Attachment 4).

Jerry Slaughter, Executive Director of the Kansas Medical Society, reiterated the Society's belief in the point of service option being a part of all managed care programs (Attachment 5). Deductibles are usually higher when out of network services are sought but it depends how the plan is designed. The weakness of the bill is that 70% of "X" can be any amount, however, "reasonable and customary" charges were addressed in recent legislation.

Taylor Markle, D.D.S., was introduced to the Committee by Dave Hanzlick, both representing the Kansas Dental Association. Included in his testimony were press accounts questioning the wisdom of making health care decisions based solely on economic considerations (Attachment 6).

Bob Williams, Executive Director of the Kansas Pharmacists Association, explained how pharmacists and their patients have been negatively impacted by the increased utilization by third parties of closed networks. These closed networks require beneficiaries to obtain their drugs from a limited network or out-of-state mail order pharmacies (Attachment 7). Pharmacists in the rural areas have been particularly affected. Recent studies show that when patients experience difficulty in accessing their prescriptions, non-compliance results with a higher incidence of emergency room visits and hospitalizations. The proposed legislation is pro-consumer in that it offers options to patients. A large exodus from a managed care plan would not be expected if the plan was meeting the needs of the patients.

Debbie Folkerts, ARNP, FNP, representing the Kansas State Nurses Association, spoke on behalf of the bill because it would further access health care by permitting qualified providers to receive partial reimbursement for services performed (Attachment 8).

Carole Gates, Legislative Chair for Kansas Managed Health Care Association and Regional Vice President of Government Affairs for CIGNA, voiced the following concerns (Attachment 9):

1. This mandate would eliminate HMO coverage because it allows all enrollees to go outside the network.

2. Purchasers of HMO will have no choice on this benefit.

3. Plans are more expensive with point of service option included.

4. Mandating 70% reimbursement does not allow flexibility for those wanting to keep premiums down.

5. Medically "necessary" should be substituted for medically "appropriate."

This bill allows the employees to make the choices rather than allowing employers to draw up the medical coverage plans. This will drive the costs up. The out of network service would be rather expensive for the consumer as balance billing would occur with no cost controls.

Jim Schwartz, Jr., Kansas Employer Coalition on Health, Inc., spoke in opposition to the bill as forcing members of an HMO to buy coverage they may not want: out of network service (Attachment 10) In some situations groups have sponsored a plan with a closed network because they would rather have higher wages and other benefits rather than more liberal health insurance. Employees who are unhappy with network access are instrumental in having such plans changed if they are unsatisfactory. The current managed care health plans are holding down health care costs. Those unhappy with restricted access are those providers who are losing business in the managed care environment. Many groups offer POS plans alongside HMO's as long as

the employee contribution to premium reflects the excess cost.

Bill Sneed, Health Insurance Association of America, reminded the Committee that the proposed legislation would prohibit insurance companies and health maintenance organizations from limiting insureds' access to covered treatment out of network, and requires that insurers pay a 70% benefit for covered out of network services which are medically appropriate (Attachment 11). This would lessen incentives for insurance companies and HMO's to keep health care costs down. Only 40% of Kansas insureds would be affected as nearly 60% of Kansas insureds are covered by ERISA plans not affected by state law. Mr. Sneed told the Committee problems with the proposed legislation are:

1. There has been no determination of what reasonable cost is and this could often be more than network costs.

2. Managed care was provided by employers and they must make the decisions.

3. Point of service plans are more attractive in the marketplace but at a much higher cost.

4. Kansas law would require a fiscal impact report prior to legislation.

Terry Leatherman, Executive Director of t he Kansas Industrial Council, a division of the Kansas Chamber of Commerce and Industry, voiced concern of how this bill might reverse the effectors to control health insurance costs (Attachment 12). If negotiated fees are lost because exclusivity has been compromised, then the net effect of the bill might be higher insurance costs and more Kansans joining the roster of the state's uninsured population.

Brad Smoot, Legislative Counsel of Blue Cross Blue Shield of Kansas, explained the coverage under Premier Blue which is an affiliated health maintenance organization (Attachment 13). He explained the benefits of a single primary care physician to manage all of a patient's case with the option of referral as needed. The exception to this is the "well-woman benefit" that permits OB/Gyn services through a contracting physician rather than going through the primary care physician. The overall management of the plan for total patient care costs less than an insurance program that provides benefits on an open panel, unrestricted basis. An option is available which allows for self-referral with a separate deductible and coinsurance policy. Adoption of this legislation would lower the volume of health care maintenance organizations and increase the costs by 50%.

Dr. Bruce Barter, Humana Health Care Plans, explained that HMO's manage care as well as costs (Attachment 14). Managed care is a style of practice which incorporates such skills as:

1. Learning to function as a primary care physician. Specialists learn to work with physicians.

2. Learning to work as a member of a coordinated team to provide care to members.

3. Learning to use outcomes based empirical guidelines.

4. Learning to use a sequential approach based on probabilities for outpatient diagnosis, rather than the shotgun approach most physicians learn in their training.

Additional costs associated with out of network use exceeds the 30% difference between what is considered reasonable and what is actually paid.

Discussion and action on HB 2843 - Uniform transfer on death security registration act

Representative Cox proposed an amendment which would add "persons or owners" on Line 18. Motion was seconded by Representative Correll.

Representative Donovan moved that the bill be passed out favorably as amended. Motion was seconded by Representative Landwehr. Motion carried.

Discussion and action on HB 2691 - Motor vehicles; proof of financial security

Representative Dawson moved to accept the balloon amendment as proposed by the Division of Motor Vehicles and explained by Bruce Kinzie of the Revisor's office (Attachment 15). The motion was seconded by Representative Vickery. Motion carried.

Representative Cox moved that the bill be passed out favorably as amended. Motion was seconded by Representative Gilbert. Motion carried.

Discussion and action on HB 2652 - Kansas automobile injury reparations act, self-insurers, requirements

A substitute bill was distributed which would require rental companies to provide liability coverage when rental drivers do not have liability coverage (Attachment 16). This substitute bill meets the requirements of the rental car agencies and the Insurance Department.

Representative Graeber moved to amend the bill as a substitute bill and pass the substitute bill out favorably. The motion was seconded by Representative Landwehr. Motion carried.

Representative Correll moved for the approval of the minutes of the February 19 meeting. The motion was seconded by Representative Cox. Motion carried.

The meeting was adjourned at 5:05 p.m. The next meeting is scheduled for February 22, 1996.

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 2/21/96

NAME	REPRESENTING
Bill Sneed	HSAA
David C. Hill, PhD	KPA
H. Darby Stotler, PhD	~~KPA~~
Connie Jeffries HCAP	KSNA
Brad Smart	
Lee Wright	
Dave Hanson	
Kevin Davis	Am Family
John Bottenberg	
Tom Wilder	
Lana DiCaursay	
Cheryl Dillard	
John Smith	
Betty McBride	
John Peterson	

KANSAS PSYCHOLOGICAL ASSOCIATION

HB 2985 (POINT OF SERVICE) PROPONENTS

KANSAS PSYCHOLOGICAL ASSOCIATION

KANSAS MENTAL HEALTH COALITION

KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE

KANSAS MEDICAL SOCIETY

KANSAS CHIROPRACTIC ASSOCIATION

KANSAS DENTAL ASSOCIATION

KANSAS OCCUPATIONAL THERAPY ASSOCIATION

KANSAS OPTOMETRIC ASSOCIATION

KANSAS PODIATRIC MEDICAL ASSOCIATION

KANSAS SOCIETY OF ANESTHESIOLOGISTS

KANSAS STATE NURSES ASSOCIATION

KANSAS PHARMACISTS ASSOCIATION

House FDSD
Attachment 1
~~2/15/96~~ 2/21/96

Central Office / 400 SW Croix / Topeka, Kansas 66611 / (913) 267-7435
Official Affiliate of the American Psychological Association

DAVID O. HILL, PH.D., P.A.
LICENSED PSYCHOLOGIST

5350 WEST 94TH TERRACE, SUITE 204, PRAIRIE VILLAGE, KS 66207
PHONE 913-341-5115
FAX 913-341-1641

February 21, 1996

Testimony before the House Committee on Financial Institutions and Insurance

RE: HB 2985: An act relating to insurance; concerning accident and sickness insurance; providing for out-of-network access

Freedom of Choice in Health Care

The debate about containing health care costs in Kansas reflects the national debate in the sense that consumers, providers and insurers must face the fact that on the cost trajectory that had been established over the past ten to twenty years, the expense of delivering health care services would overwhelm the economy. However, it is important to recognize that health care costs have spiraled in large part because health care in Kansas, and the rest of the country, has evolved into the most advanced and effective system in the world. The advances in diagnosis, treatment, and technology over the past twenty years are unprecedented. The dramatic increases in survival rates; early diagnosis and treatment; and prevention have occurred because our health care system has provided for basic research and good clinical research; improved access to care; and patient choice in selecting providers.

One of the key issues in the success of the U.S. health care system has been the maintenance of freedom of choice in selecting providers. The health care system in the state of Kansas has provided prompt and direct access to health care for the vast majority of its population. However, in the rush to contain cost, it is important that unnecessary impediments or barriers to appropriate services not be arbitrarily raised. The patient's first point of contact should be encouraged to make all needed health care referrals and should not feel constrained financially from doing the best job for the patient. Patients should also be able to opt out of any closed system to seek needed services. Hence, Legislation must ensure that enrollees in <u>all</u> managed care plans have the right to access the provider of their choice by having an <u>Out of Network or Point of Service (POS) guarantee.</u> This arrangement will permit enrollees to retain or develop professional relationships with providers of their choice. This is particularly important in rural areas, where a strong sense of community reinforces the use of local providers, and where it is

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Attachment 2
2/21/96

often geographically impossible to access providers within a specific network. The POS guarantee enables enrollees to access appropriate specialized health services for themselves and their families.

POS and Quality Assurance

The lack of quality assurance checks is widely recognized as a major flaw of the largely unregulated managed care industry. The real solution to the quality assurance issue will result from legislation which makes managed care companies responsible to act in a clinically responsible and ethical manner in their treatment decisions and in their advertising in the same way that health care practitioners are held responsible (e.g., "A Letter to Kathleen Sebilius", Kansas Psychologist, December, 1995). In the meantime, a POS guarantee serves as a quality assurance check simply by permitting patients to seek care from specialists outside the network if appropriate services are not available in network.

Financial Impact of POS

A health care plan may include a POS guarantee at no additional cost to the health plan. To get medically or psychologically necessary out-of-network care, patients agree to pay a higher reasonable copayment at the time they need the care. The health plan pays a portion of the outside provider's bill, though no more that it pays a network provider and the patient pays the balance as a copayment.

A study performed by Coopers and Lybrand (Pricing Analysis for Point of Service Plans, May 16, 1995) demonstrates that depending on how benefits are organized, a POS guarantee may actually save money. For example, taking a typical HMO benefit scenario, the Coopers and Lybrand data indicate that a POS plan with $250 deductible and 30% coinsurance will cost 1.8% less than a comparable HMO in network plan with a $5 copay for office visits. Even the Congressional Budget Office (CBO) has conceded that a POS option need not cost the system money. In senate testimony earlier this year, CBO Assistant Director Paul Van de Water said, "The POS option would permit Medicare enrollees to go to providers out of the HMO's panel when they wanted to, and yet it need not increase benefit costs for either the HMO or Medicare" (CBO

Testimony before the Committee on the Budget, United States Senate, February 1, 1995).

The Difference between Choice of Provider and Choice of Plan

Consumers are bewildered by the "language of managed care" which uses esoteric and vague terms. Further, the language of managed care often does not reveal the differences between the managed care system and the fee for service system. Instead, managed care plans are often marketed as offering "equivalent service for less money". Unfortunately, consumers often find that in exchange for lower insurance premiums, they sacrifice the option to choose their providers, and find that they have no recourse when the available provider does not meet their needs. Too often, the consumer then finds that they are offered the chance to select another plan only once a year (or less often). In other words, the consumer is offered a "choice of plans" at prescribed intervals, but is not offered the "choice of providers". The POS guarantee offers consumer protection by continuing to allow choice of provider, yet at the same time does not have to increase cost to the system.

H. DARBY TROTTER, PH.D., P.A.
CLINICAL AND CONSULTING PSYCHOLOGIST

ASSOCIATES IN CLINICAL PSYCHOLOGY
5350 WEST 94TH TERRACE, SUITE 204
PRAIRIE VILLAGE, KANSAS 66207
(913) 341-5115

February 21, 1996

HB 2985

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

Testimony In Support Of A Guaranteed Out-of-Network Access For Health Care Services That Puts "Care" Back Into Managed Choice Insurance.

During the past 15 years, there has been an explosion of new health care delivery systems that supposedly offer excellent medical care in a less costly fashion. These new delivery systems were designed to replace the Fee-For-Service delivery system that had long been an American tradition. Few would not rate Fee-For-Service as a luxury vehicle. But, like many luxuries, the Fee-For-Service system was a real gas guzzler. Nonetheless, it had become the most advanced treatment system in the world. The advances in treatment and the successes obtained were unparalleled. However, cost issues began to change the face of health care practice. Increasingly, the Fee-For-Service system was characterized as encouraging greedy health care providers who engaged in redundant and liability driven testing and unnecessary hospitalizations. The simple fact was that insurance premiums were becoming too costly.

The huge amount of health care money that could be diverted to an innovative system of health care and the need of business and industry to find a less costly delivery system gave rise to a number of health care experiments. Frankly, the effects of these new delivery systems on the health of our society have yet to be fully assessed. Therefore, it is most appropriate to refer to them as experiments. In any case, in a speed that even surprised these innovators, H.M.O.'s, P.P.O's, Managed Care, Managed Choice, and all the similar concepts were almost over night adopted by a society in a recession and over its head in debt with an over-abundance of health care providers with too many openings in their schedules. Business and industry were impressed by the "good care at less cost" proposals. Subscribers, looking for ways to cut insurance costs, were equally impressed and high new managed care companies grew and began to aggressively compete with each other. The obvious was only too clear to these new health industries, that is, they must deliver the least costly product that provides adequate care. "Therein comes the rub", as it is said.

Attachment 3
2/21/96

The articles listed below are the tip of the iceberg. They all point in a similar direction.

"HMO: How Much, Not How Well, When companies go shopping for plans, quality ratings are given short shift". Washington Post, January 19, 1996

"How Your HMO Could Hurt You". U.S. News & World Report, January 15, 1996

"Medicare payment rules endanger many hospitals. Payment system enriches HMO's while impoverishing teaching hospitals." U.S.A. Today, January 27, 1996

"Ethics pinched by the system, lawyers say. `Assembly-line medicare' has human cost". U.S.A. Today, January 22, 1996

"Gagging the Doctors", Time, January 8, 1996

"The Soul of an HMO. Managed Care is certainly bringing down America's medical costs, but it is also raising a question of whether patients, especially those with severe illness, can still trust their doctors". Time, January 22, 1996

"When Aids Patients Confront the Managed Care System". New York Times, January 18, 1996

"Maryland: Health Secretary proposes HMO regulations responding to concerns that managed care plans make too much profit while providing too little service". American Healthline, January 16, 1996

"Managed Care: California Case Raises Quality Questions". American Healthline, January 17, 1996

As these articles suggest, the public is increasingly becoming skeptical of the claims that managed care programs can both hold down costs and provide reasonable health care services. It should be no surprise to legislators that the public is beginning to press for legislation to prevent managed health care from limiting their choice of provider and the opportunity they have to receive good services, e.g., extended health benefits, portability, and elimination of pre-existing condition clauses.

The public has discovered there is an "iron fist" in the "velvet glove" of managed care insurance. The public is quite perceptive.

All of the financial risks have been transferred from insurance companies to the public. The access to treatment has become more difficult, confusing and conservative. The managed care companies have presented the policy holder with a confusing set of regulations that are designed to lower costs. For example, these companies almost all endorse the following cost control concepts:

1. Limited benefit plans.
2. Exclusion of coverage for pre-existing conditions.
3. Pre-certification prior to treatment.
4. Authority to determine what is a medical necessity, i.e., how much treatment is approved for a particular illness ("the managed care gold mine".
5. Conservative lifetime limits.
6. Limited choice of doctors.
7. Financial incentives to the doctor who does not make referrals to specialists.
8. Financial incentives to the doctor who does not order extensive medical testing.
9. Gag rules to prevent doctors from discussing treatment options with patients.

One of the promising trends is that employers nationwide are listening to their employees' demands to have freedom of choice regarding provider and treatment. 23% of all companies responding to a survey indicated they offer a point-of-service option which tripled last years figure. (Business and Health, November, 1995). According to the Group Health Association of America, the trade association for managed care companies, "63% of all managed care plans offered a point of service option in 1994, including the major staff model HMO's such as Kaiser. Within these plans, only 16% of enrollees, on average, ever used this option to go out of network". There is no evidence that plans lost money on this feature. A report issued by Milliman and Robertson in 1993 affirmed that any loss is unlikely. It was reported that these health plans recognize the need for a competitive edge that point of service options provide. Consumers want and deserve the option to seek better care when their network is not performing. (Coalition for Health Care Choice and Accountability, February, 1996).

While this legislation doesn't fix everything wrong in the managed care industry, it softens the cost driven iron fisted health care system. In a competitive climate in 1996 which could turn ugly as managed care companies try to further drive down costs, point-of service allows a relief value for individual policy holders. The

pendulum has swung too far. Until a new system emerges that properly balances care and costs, legislation such as this will be necessary to protect consumers. This legislation expands opportunities for treatment and choice of providers so people can get the best quality of help available, even if they must pay more to be able to exercise the right of freedom of choice.

Kansas
Chiropractic
Association

**Before the House Financial Institutions
and Insurance Committee
February 21, 1996**

**Testimony of Joe Furjanic
Executive Director, Kansas Chiropractic Association
In Support of HB 2985**

Mr. Chairman and members of the Committee, thank you for this opportunity to speak in favor of HB 2985.

The Kansas Chiropractic Association (KCA) supports HB 2985 because it provides a mechanism for patients to have out of network access to the provider of their choice in a manner that is equitable to the patient, the out of network provider, and the network itself.

This bill is fair to all parties and provides needed access to health care while not adversely impacting on insurance networks.

Thank you for your time. I will be happy to respond to questions.

House FI&I
Attachment 4
2-21-96

1334 S. TOPEKA BLVD. • TOPEKA, KANSAS 66612-1878 • (913) 233-0697 • FAX (913) 233-1833

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 21, 1996

TO: House Financial Institutions and Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: HB 2985; concerning access to out-of-network providers

The Kansas Medical Society appreciates the opportunity to appear today on HB 2985, which requires health insurance policies to cover out-of-network providers. We are generally in support of the concept, and believe the market is heading that way anyway. This bill would assure patients that they could go to the provider of their choice, albeit with an out-of-pocket cost.

The part of the bill which requires a reimbursement benefit equal to 70% of "reasonable" charges could be problematic, and may be too costly to mandate on health plans. Since there is no limit on what constitutes a reasonable charge, there could be substantial cost implications. Notwithstanding that, however, we support the concept of broad access to providers which is contained in this bill.

House F.I. & I.
Attachment 5
Feb. 21, 1996

KANSAS DENTAL ASSOCIATION

Statement by Taylor Markle, D.D.S.
In support of H.B. 2985
Before the House Committee on Financial Institutions and Insurance
February 21, 1996

Chairman Bryant and members of the Committee, my name is Taylor Markle. I am a practicing oral and maxilofacial surgeon in Shawnee, Kansas, and the Legislative Chairman of the Kansas Dental Association.

On behalf of the Kansas Dental Association, I am pleased to support this important legislation to provide patients with the ability to seek the care of an out-of-network provider and receive a benefit equal to 70 percent of the reasonable charges for services that are medically necessary and are covered under the plan.

The Kansas Dental Association believes this legislation is an important step forward in assuring patients of reasonable access to the health care provider of their choice.

I have attached to my testimony are several of a growing number of press reports that call into question the wisdom of making health care decisions based almost solely on economic considerations. These press accounts, I believe, point out very clearly why this bill is necessary.

The fundamental issue is this: When you or a loved need delicate and complex surgery, do you want that surgery to be performed by the best practitioner available or by the one who was willing to accept the rate offered by the health care plan? H.B. 2985 provides the individual with the freedom to make that important choice.

Thank you for your time and consideration.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

House F I & I
Attachment 6
Feb. 21, 1996

Cutting Costs—or Quality?

The pursuit of health care savings may be increasing the risks for patients

By David S. Hilzenrath
Washington Post Staff Writer

Costella Prince Thompson was feeling wretched when she went to a Group Health Association Inc. urgent care center on March 12, 1992. Since undergoing general anesthesia for arm surgery a little more than a week earlier, she had experienced a sore throat and a cough along with diarrhea, chills, nausea and vomiting.

At the health maintenance organization, the 53-year-old Washington, D.C., schoolteacher was examined by a physician assistant, who prescribed some medicine and sent her home with instructions to stay in bed for four days.

A day later, Costella Thompson was dead. An autopsy revealed pneumonia and other serious problems that the physician assistant had missed, apparent complications of her surgery.

A District of Columbia jury faulted the care Thompson received at GHA, but decided five months ago that the HMO was not to blame for her death.

As cost-conscious insurers transform the health care system, some experts are applauding them for bringing greater efficiency to medicine. But many patients and medical professionals, citing cases such as Thompson's, argue that the system is cutting corners as well as costs.

Silver Spring, Md., physician Bernard A. Heckman sees Thompson's case as an example of the potential trade-offs society faces in its push for more economical health care. "The emphasis on cost containment is going to bring about a deterioration in overall quality of care," he says.

There is little if any authoritative data to show whether the quality of medical care is getting better or worse overall—in fact, there is little consensus as to how to measure quality, experts say. But the first signs are appearing that Americans will have to accept compromises when they seek medical services.

A recent survey by the Robert Wood Johnson Foundation found that sick patients enrolled in "managed care"—the rapidly growing form of health insurance that tries to contain spending on medical services—had many more complaints about their care than sick patients with traditional "fee-for-service" insurance coverage.

Managed care patients were at least 40 percent more likely than fee-for-service patients to report that they had problems getting needed treatment, were unable to see a specialist when needed, were unable to get needed diagnostic tests and had to wait a long time for routine appointments.

At one Fortune 500 company, 26 percent of the people who sought treatment for mental health or substance abuse problems through the employee benefits program received no care within three months of requesting it, largely because of delays in administrative problems, according to James Wrich, a Chicago consultant who was hired by the company to evaluate the program. The benefits plan required therapists and patients to get treatment approved in advance by a managed care contractor, which reduced expenses by about 30 percent.

Generally, "you had to have a serious crisis . . . in order to get help," Wrich says.

At California Pacific Medical Center in San Francisco, organ transplant specialists have turned down patients who might have been given transplants in the past even though they had poor prospects for recovery, says Barry Levin, vice chairman of the hospital's department of transplantation. Without transplants, these patients have no chance of survival, he says.

BECAUSE HEALTH INSURANCE PLANS NOW CAP payments for the surgery and follow-up care, "the sicker the patient is, the less chance you're going to have . . . of making a profit or breaking even on the case," Levin says. "You unconsciously or even consciously begin to look at patients differently."

One HMO doctor refused to see a woman who repeatedly sought an appointment for chest pains, says Margaret E. O'Kane, president of the National Committee for Quality Assurance, an accrediting agency that monitors quality control in HMOs. Traditional health insurers pay doctors a fee for each office visit, which critics say encourages unnecessary care. But the HMO paid this doctor a fixed monthly fee to provide all of the patient's primary care, whether the doctor saw the patient or not—an increasingly common approach.

In Easton, Md., physician Donald T. Lewers, a trustee of the American Medical Association, says one health insurance plan refused to pay for Pravachol, the drug he had been prescribing to control a retired factory worker's high cholesterol. The insurer insisted that the woman instead use Mevacor, made by a different manufacturer, even though Mevacor had proved less effective for this patient when she had tried it several years ago, Lewers says. Unable to pay for Pravachol out of her own pocket, the patient switched to Mevacor in February, which placed her at increased risk of heart attack or stroke, Lewers says.

A spokesman for Merck & Co., which makes Mevacor and administers this patient's prescription drug benefit through a subsidiary, says the plan would cover Pravachol if the doctor wrote a note that it was medically necessary. Lewers says the company representative who asked him to switch the prescription did not mention that option.

"We'll have to make some sacrifices and pay a price for less costly medical care," says Stanford University health economist Alain C. Enthoven, who sees the health care revolution doing more good than harm. "That means everybody can't have everything all the time. . . . In some cases that may reduce the quality of care."

At a June meeting in Jackson Hole, Wyo., a group of large employers who have helped lead the drive for less expensive health care resolved that they would develop better ways of tracking changes in their employees' health. The current focus on costs "could be ruinous to the health care system" unless it is balanced by greater emphasis on medical results, says Dwight N. McNeill, an employee health benefits manager for GTE Corp. and a coordinator of the group's efforts.

Even some of the most vocal critics of the cost-cutting measures agree that the health care system must be made more efficient. Rising medical bills have become a heavy burden for society, pricing private health insurance beyond the reach of millions of Americans, threatening to overwhelm the government health insurance programs for the poor and the elderly, and diverting money from other priorities.

Neil Schlackman, medical director of U.S. Healthcare Inc., a large HMO company based in Pennsylvania, says the nation has been consuming so much unnecessary, inappropriate and potentially harmful medical care that it is possible to improve quality while cutting costs.

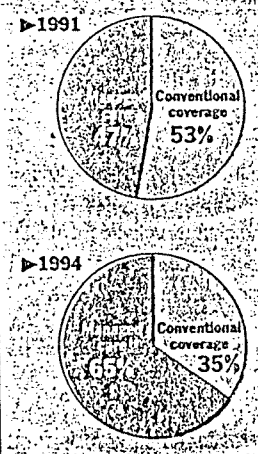
"I think we're still [cutting] fat," Schlackman says, echoing the view of many in his industry. "There's a huge opportunity still available before we get into muscle and bone."

THE DRIVING FORCE BEHIND health care cost-cutting has been big employers' search for less expensive ways to provide health benefits for their workers—and the rise of managed care health insurance plans such as HMOs to do the job.

Where traditional insurers simply paid their customers' medical bills, managed care plans often require doctors to get approval before ordering certain tests or procedures. They steer patients to doctors and hospitals that accept their reimbursement rates and meet their standards. Patients who seek care elsewhere must pay a larger percentage of the charges or the entire cost themselves.

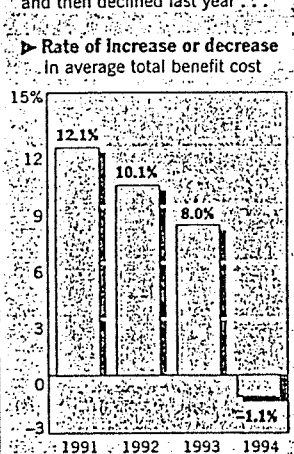
THE COSTS OF MANAGED CARE

As more people in the U.S. moved into managed care plans . . .



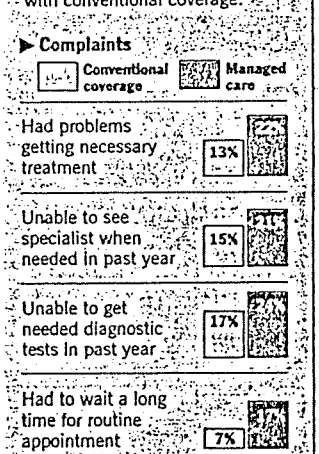
SOURCE: KPMG surveys of employer-sponsored health benefits, which reflect employers with 200 or more workers

. . . The average cost of employer-sponsored health benefits grew more slowly in 1992 and 1993 and then declined last year . . .



SOURCE: Foster Higgins national survey of employer-sponsored health plans, which reflects employers with 10 or more employees

. . . But certain complaints seem more common among managed care patients than among patients with conventional coverage.



SOURCE: Robert Wood Johnson Foundation survey of non-elderly people who were sick

W Post Weekly
8-28-95

6-2

of HMOs as far as we can tell, the denial of needed services is not a major problem," says Bruce C. Vladeck, administrator of the Health Care Financing Administration, which oversees federal insurance programs for the poor and elderly. But, speaking generally, he adds, "We have a long history . . . of really fundamentally abusive or dishonest plans where the denial of service has been part of the get-rich-quick strategy."

Managed care plans covered 65 percent of workers insured through mid-size and larger employers last year, up from 29 percent in 1988, according to the consulting firm KPMG. Doctors who lose favor with those health plans on grounds of cost or quality may be cut off from large blocs of patients and major sources of income.

One mental health professional says she has become hesitant to accept severely ill patients or see patients more than once a week as a result of warnings that Mid Atlantic Medical Services Inc. (MAMSI), a Rockville, Md.-based managed care company, has issued about "utilization"—jargon for services delivered or resources consumed. "It makes me very cautious to take patients who require any kind of intensive treatment," she says, speaking on the condition that she not be identified.

She is referring to messages such as an Aug. 9, 1994, letter to Mid Atlantic mental health providers in which Assistant Medical Director Mark D. Groban said: "Those providers who maintain significantly higher utilization than their peers will have additional utilization management review of their MAMSI case load to ensure that only high quality and medically necessary care is being delivered. . . .

"We have a large waiting list in each of our mental health specialties and see no reason to ask providers to work with us in a model that is uncomfortable for them."

■

WASHINGTON MALPRACTICE ATTORNEY JACK H. Olender says he believes a cost-sensitive atmosphere contributed to Group Health Association's failure to diagnose the colon cancer afflicting his client, Lilia M. Reyes.

Beginning in October 1991, Reyes, a program manager for the U.S. Conference of Mayors and a mother of two, complained to GHA of abdominal pains, bowel irregularities and other problems. By early 1992, when blood was detected in her stool, she told her GHA doctor that she feared she had colon cancer, according to court records of a malpractice suit.

At a trial last year, expert witnesses for Reyes testified that at the outset of Reyes's treatment she should have been given a sigmoidoscopy, which almost certainly would have revealed her problem. A cancer specialist called to testify by the HMO said that test would have been "acceptable" but not "necessary."

Physician Karen Bledsoe, an employee of the HMO at the time, diagnosed Reyes's problem as irritable bowel syndrome. Bledsoe testified that, before she could refer a patient to a specialist for a sigmoidoscopy, she would have to submit a form for review by GHA's chairman of internal medicine. She said she was denied such requests in some other cases.

Reyes's cancer was diagnosed in August 1992 when she underwent emergency surgery while on vacation in Florida. A tumor had blocked her colon. One of Reyes's experts testified last November that he "would be surprised if she is still alive in a year."

Reyes, 44, says that she gave up her traditional health insurance and enrolled in GHA in 1991 because the premiums were lower. "Sometimes you try to cut corners thinking you're going to be saving some money, and ultimately you end up paying just an incredible price for it," she says.

In December, a District of Columbia Superior Court jury ordered GHA to pay damages of $2 million. The case is on appeal. A spokesman for Humana Inc., which bought GHA and renamed it Humana Group Health Plan Inc. last year, declined to comment on the Reyes and Thompson cases, as did lawyers who represented GHA.

HMOs have the potential to greatly improve the practice of medicine because they can collect data on what works and what doesn't for large numbers of patients and help standardize patient care, analysts and industry executives say. U.S. Healthcare, for example, sends doctors and patients periodic reminders for vaccinations, mammograms and other screenings. Last year, the Pennsylvania-based company began sending letters to all the suspected diabetics in its HMOs and their physicians, saying the patients should get annual eye exams because diabetes would put them at higher risk of developing a retinal problem. The percentage of suspected diabetics receiving eye exams rose to 41.6 percent in 1994 from 35.9 percent in 1993, the company says.

BY CONRAD FOR THE LOS ANGELES TIMES

The first signs are appearing that Americans will have to accept compromises when they seek medical services.

On balance, Stanford's Enthoven says, care is improving as managed care systems bring independent quality control to doctors' historically autonomous medical practices.

However, the effects are difficult to quantify. "We don't have very much information on how the system is performing," says O'Kane, the National Committee for Quality Assurance president.

The financial payoff for the public is easier to see. The cost of employer-sponsored health benefits, which was rising an average of 17.1 percent in 1990, declined an average of 1.1 percent last year, according to a survey by the consulting firm A. Foster Higgins & Co. Some health plans are offering to cut large employers' rates by as much as 10 percent next year, benefits consultants say.

■

VARIOUS FINANCIAL INTERESTS CLOUD THE DEBATE over what is happening to quality and access. Many of the harshest critics of the health care revolution are doctors and nurses whose incomes are threatened. But many of the revolution's strongest exponents—the leaders of the managed care industry—are profiting greatly from the cost-cutting. They pay themselves, their employees and their shareholders with money they squeeze out of the system.

Hospitals are caught in the squeeze, and one result is pressure to send patients home more quickly.

For example, from 1984 to 1994, the average length of hospital stays declined from seven days to three days for simple mastectomies, from 11.8 days to eight days for heart attacks, and from 2.6 days to 1.6 days for normal deliveries, according to HCIA Inc., a health care information company.

Many newborn babies and their mothers are being sent home within a day of delivery. A study released in May by Augusto Sola, director of neonatal clinical services at the University of California, San Francisco, linked the declining length of hospital stays to an increasing number of cases in which newborns have developed a rare form of brain damage.

Sola says it could cost $40 million to keep newborns hospitalized long enough to prevent just one case of brain damage, but he adds that there might be a more economical alternative involving heightened follow-up care after infants leave the hospital.

In the pursuit of efficiency, hospitals, HMOs and doctors' offices have been assigning certain responsibilities to less highly skilled, less highly compensated personnel. One goal is to free the more highly trained professionals to focus on the more complicated work. Critics say the strategy may increase the likelihood of error.

At an Indiana hospital, a nursing assistant recorded an infant's temperature during a routine check of vital signs, but she did not realize that the reading was dangerously low and did not alert other members of the staff, according to her supervisor.

At Group Health Association, the physician assistant who examined Costella Thompson the day before she died "could not be expected to know any better," but the HMO erred by allowing him to treat Thompson's "life-threatening illness," Heckman, a gastroenterologist, said in a deposition for a lawsuit filed by Thompson's widower, Duane E. Thompson.

According to an autopsy report, Thompson was suffering from a punctured esophagus, an internal abscess that extended from the surrounding tissue to her lung, and pneumonia. The puncture apparently occurred when a tube was inserted in Thompson's throat during her March 4, 1992, operation.

Physician assistants, certified professionals whose formal training is less extensive than that of doctors, are typically paid about half as much as family physicians and play an increasingly important role in health care. "Although once considered with trepidation, physician extenders, such as physician assistants, nurse practitioners and midwives, are now seen as a means to boost practice productivity," an American Medical Association publication reported in February.

A District of Columbia Superior Court jury last April found that two doctors and a nurse committed malpractice in Thompson's surgical and postoperative care. The jury concluded that Group Health Association "departed from the standard of care" in Thompson's case. But it ruled that GHA's lapse was not a "proximate cause" of her death and assessed no damages against the HMO.

By the time Thompson saw the physician assistant, her illness "was too far advanced and too serious to have been reversed," Kenneth T. Larsen Jr., former chairman of the Department of Emergency Medicine at Greater Southeast Community Hospital and an expert witness for the HMO, said in a deposition. ■

6-3

COVER STORY

Ethics pinched by the system, lawyer says

'Assembly-line medicine' has human cost, says Hiepler. High-profile cases, **2D**

By David Leon Moore
USA TODAY

OXNARD, Calif. — Mark Hiepler keeps winning cases and burying clients.

The winning has made him famous in legal circles and infamous in health care industry circles.

The burying has inspired Hiepler, a 33-year-old lawyer who specializes in health care cases here, to battle daily to get medical treatment for patients within a system he believes is increasingly ethically corrupt.

His target is the denial of care and what he contends are the financial incentives that health maintenance organizations give doctors to withhold treatment.

It's a debate swirling in doctor's offices, courtrooms and within the American Medical Association, and its latest flash point is a system of paying doctors called "capitation."

Hiepler and other critics contend that under capitation, many HMOs saddle their doctors with an irreconcilable conflict of interest: looking out for their patients or watching out for their paychecks.

"I'm not trying to destroy HMOs," says Hiepler. "I'm just trying to make them accountable to the patients who make

Please see COVER STORY next page ▶

JESS MONDAY IN MONEY FOR BUSINESS

USA Today

6-4

...ne HMOs he attacks, however, ...pler is a misleading, trapped-in-his-own-rhetoric conspiracy theorist — yet another lawyer out to make a buck off someone else's pain.

"No matter what he calls himself, a crusader or whatever, he's just another plaintiff's attorney," says Don Prial, a spokesman for Health Net, the largest for-profit HMO in California with about 1.4 million members and a target of Hiepler's lawsuits.

Nor, says lawyer Mike Gonzalez, who has battled Hiepler in court, does he offer any solutions.

"The public wanted affordable health care, and HMOs are a mechanism for that," Gonzalez says. "I don't see Mark offering something better. The outcome of fee-for-service medicine was that costs kept rising and that more and more people were becoming uninsured."

Largest award against insurer

Right or wrong, Hiepler's audience is growing. The reasons are the three earthquakes he sent through the health insurance industry:

▶ In November, Hiepler won a $3 million jury verdict (reduced by a California law to around $700,000) in a medical malpractice case against two California doctors Hiepler accused of practicing "assembly-line medicine" in an "HMO mill."

His client, Joyce Ching, 34, died of colon cancer in April 1994.

▶ In October, he won a $1.2 million award against Health Net when an arbitration panel ruled the HMO improperly interfered with doctors' judgment.

His client, Christine deMeurers, 35, died of breast cancer last March.

▶ Two years ago, he won a landmark $89 million jury verdict against Health Net (the case was later settled for an undisclosed amount) after the HMO denied a bone marrow transplant to treat breast cancer.

His client, Nelene Fox, 40, died in April 1993.

The Fox case put Hiepler on the legal map. It was the largest award ever against an insurance company for the denial of health benefits.

It also shaped Hiepler's life.

Nelene Fox was his sister.

Nelene is Mark's constant inspiration, a silent partner in Hiepler & Hiepler, the law firm run by Mark and his wife, Michelle, and dedicated to fighting for HMO patients' rights.

Hiepler now sees a steady stream of clients, and since the Fox verdict, he has helped 124 of them get treatment that had originally been denied. Many were women with breast or ovarian cancer.

"When I look into the eyes of each one of these people, I usually see my sister," he says. "I will never understand why someone my sister's age, with all her abilities and so many depending on her, had to die."

'Financial incentives are to underserve'

As HMOs become major forces in more and more states, consumer groups and patient advocates report a growing chorus of complaints about denial of care.

"The more managed care permeates the country, the more the question of denial of care rises to the top," says Cathy Hurwit, legislative director of Citizen Action, a Washington, D.C., consumer group. "We're seeing a sort of mirror image of fee-for-service, which was criticized for overtreating. In managed care, the financial incentives are to underserve."

Nonsense, say the HMOs.

"The incentives are there not to withhold care," says Lyle Swallow, vice president of legal services for Health Net.

"The incentives are to make sure that unnecessary care is not provided, to provide care at the most appropriate level and to provide preventive care. Are HMOs perfect? No. Does that mean that fee-for-service is better? No."

Moreover, HMO advocates add, underserving a patient can lead to complications more costly than treating the problem outright.

In this national debate, an increasingly prominent voice belongs to Mark Hiepler.

"HMOs," Hiepler says, "have seduced us with these nickel-and-dime co-payments. ... Ninety percent of Americans are healthy, and those people love their HMO. It's the ones who are sick who ... learn too late how managed care works."

Hiepler's latest attacks have been aimed at capitation — the system by which about half of the nation's HMOs pay their doctors.

Under such a system, doctors get a flat fee per patient per month.

Capitation systems vary, but increasingly, doctors receiving larger capitation fees must pay for referrals, diagnostic tests and emergency care up to a negotiated maximum — usually $5,000 or more per patient. Beyond that, the HMO pays.

It means that if the doctors provide more in services than they receive in fees, they lose money on those patients. On patients who visit the office once a year for a checkup, the doctors make money.

This simple equation, Hiepler contends, is potentially deadly.

Dave Ching agrees.

Charges of greed 'totally unfair'

Hiepler was in the middle of his sister's case when Dave and Joyce Ching walked through his door.

Joyce had colon cancer. The tale they told about Joyce's treatment by Dr. Elvin Gaines and Dr. Daniel Engeberg, two Simi Valley, Calif., family doctors, led to a malpractice suit Hiepler hoped would put capitation itself on trial.

Joyce visited the doctors complaining of rectal bleeding and abdominal and pelvic pain. But it took 11 weeks — and repeated requests by the Chings for a referral to a specialist — before the doctors sent her to a gastroenterologist. Her cancer was immediately diagnosed. But too late. She died 20 months later.

When Hiepler first told the Chings about the capitation agreement between the doctors and Metropolitan Life's HMO, "Dave started crying," Hiepler says. "He said, 'I got screwed. We were trusting them.'"

The doctors' group — Simi Valley Family Practice (since changed to Family Health Care Medical Group — received $27.94 per month to treat Joyce and was responsible for the first $5,000 it cost to treat her.

As part of the suit, Hiepler charged a "breach of fiduciary duty," alleging that Gaines and Engeberg declined to refer Ching to a specialist because the cost of the referral would come out of their pockets.

HMOs and their critics keenly watched the case to see how the argument about capitation would play before a jury. But on the eve of closing arguments, Superior Court Judge Ken Riley threw out that portion of the suit, saying Hiepler had not made his case about financial motives.

Gaines and Engeberg were found negligent; capitation, incentives and risk-sharing were untouched.

Rightfully so, says Gonzalez, the doctors' lawyer.

"The allegations of greed were totally unfair," says Gonzalez, whose clients declined interview requests. "These doctors are wonderful men, and putting them through this mill was totally without merit."

The real reason the doctors didn't refer Ching to a specialist earlier, Gonzalez says, is because it's rare for a woman of that age to have colon cancer.

Maureen O'Haren, a lobbyist for the California Association of HMOs, says the Ching case, while tragic, was no indictment of HMOs or their business agreements with doctors.

"I just don't think doctors are refusing to treat something that might be serious to save a little money," O'Haren says. "And these doctors didn't save any money. They ended up having to pay the full $5,000."

Hiepler contends, however, that in big medical groups like Gaines' and Engeberg's, gambling that someone *isn't* sick is financially worth the risk.

"You save a little money on each patient, multiply that by thousands of patients, and you've got a very profitable way of doing business," he says. "And you've got enough money to gamble on someone becoming sick. After all, most people don't have cancer. But Joyce Ching did."

Hiepler has three more cases that, if they go to trial, might include an allegation of breach of fiduciary duty. He believes the law supports such an argument but concedes it will be difficult to prove.

"The judge basically said you need a confession from the doctor, and that's not going to happen," he says. "We'd like to get it before a jury, though, describe the financial incentives and let the jury decide."

Dave Ching, who lives in Fremont, Calif., with his 5-year-old son, Justin, needs no further convincing.

"I feel good that Joyce and I were able to help him send another message," he says. "The HMOs may be too big for us to really make a dent, to make any major changes. I know one thing, though. They're wishing that Mark would just go away."

Lawyer Hiepler's high-profile cases

Fox vs. Health Net

▶ **The facts:** Nelene Fox, a wife and mother in Temecula, Calif., had breast cancer. Although her doctor recommended a bone marrow transplant, she was denied coverage. Her HMO, Health Net, considered the $150,000 procedure, with her advanced cancer, experimental. Through fund-raising, Fox underwent the treatment but died in April 1993 at 40. Her husband sued, revealing financial incentives for Health Net officials to limit expensive procedures.

Denied: HMO didn't cover transplant for Nelene Fox, with husband Jim and Nicole, left, Natalie and Jenna.

▶ **The verdict:** In December 1993, a Riverside (Calif.) County jury found Health Net's refusal constituted a bad-faith breach of contract. The jury awarded the Foxes $89 million, including $77 million in punitive damages. Health Net filed a motion for a new trial but reached a settlement for an undisclosed sum.

Ching vs. Gaines et al.

▶ **The facts:** Joyce Ching, a wife and mother in Agoura, Calif., was enrolled in a Metropolitan Life HMO. She visited her primary care doctor, Elvin Gaines of Simi Valley, Calif., complaining of abdominal pain and rectal bleeding. For almost three months, Ching and her husband requested a referral to a specialist but were denied. When she was finally referred to a specialist, she was diagnosed with colon cancer. She died in April 1994 at age 34. Her husband, Dave Ching, sued Gaines, Dr. Daniel Engeberg and their medical group for malpractice. Hiepler, Ching's lawyer, also alleged a breach of fiduciary duty, charging that the doctors, because they were being paid a capitated fee of $27.94 a month to treat Ching and would have to pay out of their pocket for costs exceeding that amount, were motivated financially to deny referrals.

▶ **The verdict:** In November, a Ventura County (Calif.) jury found Gaines and Engeberg negligent and awarded $3 million in damages — reduced to about $700,000 under a California law. The judge, before closing arguments, threw out the part of the suit alleging that Gaines and Engeberg acted out of greed.

deMeurers vs. Health Net

▶ **The facts:** Christine deMeurers, a teacher, wife and mother in Lake Elsinore, Calif., had breast cancer. She was approved for a bone marrow transplant by her doctors. Health Net, her HMO, refused coverage because it considered the treatment, in her case, to be experimental. UCLA paid for the treatment but deMeurers died last March at age 35. Her husband sued Health Net.

▶ **The decision:** In October, a three-person arbitration panel ruled that Health Net breached its contract in bad faith and intentionally inflicted emotional distress. Health Net, the arbitrators wrote, "crossed the line" in improperly seeking to influence doctors' medical judgment. The arbitrators awarded $1.2 million in damages.

Arbitration: The HMO 'crossed the line' in the case of Christine deMeurers, left, with family Alan, Jeffrey and Michelle.

6-5

When doctors become sub-contractors of medical care

The arrangement is called "capitation," and it's the latest flash point in the battle over HMOs.

HMO models vary widely, but the fastest-growing plans these days are called "network" models or IPAs (independent practice associations), in which independent doctors, usually banding together in large medical groups, contract with HMOs.

Under more than half of these plans, doctors receive a flat fee from the HMO for every patient. That's capitation.

Some capitation payments are as little as $8 or $10 a month, in which case the doctor is usually responsible for primary care only.

A growing number of contracts, however, require doctors to share the risk of insuring patients. Under such agreements, HMOs pay doctors larger capitation amounts — typically $30 to $35 — to provide all outpatient care.

The doctor then must pay for referrals, diagnostic tests and emergency care up to a negotiated maximum per patient — typically $5,000 or more. Beyond that, the HMO pays.

The idea is that when doctors are paid up front, they have the incentive to provide preventive care and keep their patients healthy.

And indeed, most patients remain healthy, visit their doctors infrequently and cost little to treat. Doctors make money on these patients, and the monthly payments for them provide the funds for doctors to treat sick patients.

But with sick patients, critics say, doctors are put into a conflict of interest: They lose money by treating aggressively.

"Every time the doctor says no, it means more money in his pocket," says Dr. Wayne Nishigaya, a family doctor in Anaheim, Calif. "That's a horrible system. It can be a real incentive to not do something."

The American Medical Association's policy statements say that managed care financial incentives, including capitation, "are not inherently unethical."

However, says a report from the AMA's Council on Ethical and Judicial Affairs, the incentives can be unethical, "depending on their design and intensity."

The AMA maintains that rules in many HMOs preventing doctors from talking about the plans and their incentives "are totally unethical and should not be tolerated," according to Dr. Nancy Dickey, current AMA chairman.

In general, Dickey says, "it's very difficult to say this particular amount or that amount is wrong when it comes to incentives. But where the incentives are so intense that the physician's ability to make good care decisions is overwhelmed by monetary decisions, those decisions are unethical."

By David Leon Moore

Three questions to ask your HMO

Consumer advocates say patients need to be more informed and persistent about their rights.

Since HMO and other managed-care plans vary widely, they suggest getting answers to these questions before joining an HMO:

▶ Do primary care doctors get more money if they deny referrals to specialists?

▶ Can the HMO terminate its contract with the doctor if the HMO believes the doctor is overutilizing services?

▶ Do primary care doctors receive bonuses from the HMO if they limit referrals?

Maureen O'Haren of the California Association of HMOs says that if HMO doctors disclose their incentives, then so should fee-for-service doctors, who have been criticized for ordering unneeded tests to make more money.

THE KANSAS PHARMACISTS ASSOCIATION
1308 SW 10TH STREET
TOPEKA, KANSAS 66604
PHONE (913) 232-0439
FAX (913) 232-3764

ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY

HOUSE COMMITTEE
FINANCIAL INSTITUTIONS AND INSURANCE

FEBRUARY 21, 1996

HOUSE Bill 2985

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the committee regarding House Bill 2985.

While HB 2985 is not a panacea, it is a step in the right direction to providing appropriate care for Kansas residents. Pharmacists and their patients have been particularly hit hard with the increased utilization by third parties of closed networks which require beneficiaries to obtain their drugs from a limited network or out-of-state mail order pharmacies. This requirement forces patients to sever long-standing professional relationships they have had with their pharmacists for many years--in some cases these relationship span generations. Some would have you believe closed networks are a necessary component of managed care. As far as drug therapy is concerned, closed networks have done very little, if anything, to manage care or cost. When barriers are created which prevent a patient from easy access to their prescription medication--non-compliance increases which results in higher cost in other areas such as emergency room visits and hospitalizations. Recent studies bear this out.

According to a recent study conducted by L. Lyle Bootman, Ph.D. entitled "Drug Related Morbidity and Mortality: A Cost Illness Model," published in the October 9 *AMA's Archives of Internal Medicine* the cost of drug related morbidity and mortality is $76.6 billion

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annually. The largest component of the total cost comprised drug related hospitalizations (8.76 million admissions at a cost of $47.4 billion dollars annually). A report issued by the U.S. General Accounting office in July 1995 entitled "Prescription Drugs in the Elderly" reported that "...about 17.5% of almost 30 million non-institutionalized Medicare recipients 65 or older used at least one drug identified as unsuitable for elderly patients since safer alternative drugs exist."

Attached to my testimony is one individual's experience with a closed network. In this individual's case she and her husband are seeing three different doctors, are taking seven different medications plus two different types of insulin. They are required to purchase their maintenance medication from a mail order pharmacy. To summarize her comments, they received generic and therapeutic substitutions with no explanation; caps had come off in shipping with medication mixed up in the bottom of the envelope; received insulin which was not protected from the elements; received Lasix labeled for use by her husband but husband was never prescribed the medication; received Gemfibrozil three times but was ordered only once. Each of these incidents required a tremendous amount of time on this individual's part to correct. Had she been a less astute patient, the outcome could have been fatal. This is not an isolated incident, I encourage you to talk with your constituents regarding problems they have been having with their networks.

HB 2985 is pro-consumer. It provides patients an option if they perceive they are not receiving appropriate care from a given network. If an HMO or insurance company has a large percentage of their beneficiaries leaving their network of providers for what is essentially a 30% penalty--then that HMO or insurance company has a serious problem.

We encourage your support of House bill 2985. Thank you.

19 February, 1996

REPORT ON NATIONAL PRESCRIPTION SERVICES INC.

TO: Whom It May Concern

FROM: A Retired Federal Employee With 30 Years of Service, And His Wife, Who Have Federal Blue Cross & Blue Shield and Medicare Parts A & B Health Insurance.

RE: Pharmacy Services Implemented With National *R/x* Services, Inc. On January 1, 1996.

In December, 1995, we first learned through our local pharmacist of changes planned for Federal BC/BS and Medicare Part B participants to obtain necessary prescription medicines after January 1, 1996. Since we had received no notification from our insurance carriers, I immediately called the local office of BC/BS for Federal Employees (913-232-3379) for more information. I was told by an Ed Pate (or Pape) their office had no information they could mail to me and that they were not responsible for the changes because it was a plan for Mail Order Prescription Services implemented by the Federal Government to start on January 1, 1996. He suggested that I call the Service in Tampa, Florida (1-800-262-7898) to get needed information.

I called that number and spoke with a Stephanie Roberts who said she would mail a "Starter Kit" to us. After about two weeks and we had not received a kit, I again called 1-800-262-7898, (this time reaching their facility in Texas) and was told my request was shown in their records, but there was no verification that it had been mailed. He said the kit would be mailed that day. I asked to speak with Stephanie Roberts, with whom I had previously talked and was told they had 595 employees in their office and he did not know how to locate her. On January 17, 1996 I received a #12 size envelope from National *R/x* Services, Inc., in Tampa, Florida, with the initials "N J" written above the return address. It contained only a "Confidential Enrollee/Patient Profile" questionnaire and a business reply envelope addressed to National *R/x* Services, Inc., P.O. Box 1018, Summit, New Jersey 07902-9955.

Once again I called the 1-800 number and explained we were running low on our medicines and asked how to place an order. A person named Clem Sheridan said to expedite the process I could ask our Doctor(s) to call in the prescription to 1-800-262-7890 or fax the prescription to 1-800-837-0959. I immediately prepared individual lists for:

1. My Endocrinologist
2. Our Primary Care Physician
3. My Nephrologist .

Each of these lists submitted included the patient's name (mine or my husband's), address, insurance identification number, name of medicine, strength prescribed, number of units used daily and how many would be needed for a 90-day supply.

The following medical prescriptions were called in or faxed to the National Mail Orders *R/x* Services by nurses in our physician's offices and show the results as we know them to be:

1. NAME OF MEDICINE: COZAAR (for me)
   DATE CALLED IN: Faxed on January , 1996
   DATE PROCESSED: January 29, 1996
   DATE SHIPPED: Unknown
   DATE RECEIVED: Feb. 3 by 1st class mail

PROBLEMS ENCOUNTERED: None, except for our physician's office being unable to get through on the phone for a day and having to fax it the following day.

7-3

2. NAME OF MEDICINE: LASIX (for me)
DATE FAXED: January 30, 1996
DATE PROCESSED: February 6, 1996
DATE SHIPPED: February 6, 1996
DATE RECEIVED: February 7, 1996 by Federal Express overnight delivery

PROBLEMS ENCOUNTERED: Bottle was labeled FUROSEMIDE (generic brand) with no explanation what it was the generic for. There was no reason for it to be sent Federal Express overnight with the cost reported to be $7.50.

2a. NAME OF MEDICINE: DYNACIRC, TENORMIN, ZYLOPRIM, and LOPID (for husband)
DATE FAXED: January 30, 1996 (same as above order from same doctor)
DATE PROCESSED: February 6, 1996
DATE SHIPPED: Unknown
DATE RECEIVED: Several days later-February 9, 1996 by Priority Mail

PROBLEMS ENCOUNTERED: This order was faxed with order shown above. The bottles were labeled DYNACIRC, ATENOLOL, ALLOPURINOL, and GEMFIBROZIL. DYNACIRC was a recognizable brand name. The GEMFIBROZIL was noted on the order sheet (not on the label) as a therapeutic equivalent for LOPID, but the other two were completely foreign names with no explanation offered.

To add to the frustration the caps on the bottles had come off and the capsules and tablets were mixed together in the bottom of the shipping envelope. I checked with our local pharmacist to identify the medications and called our doctor's office for verification of the order. Our doctor said for us to report it immediately to the Mail Order *R/x* Services. I called the 1-800 number and talked with someone identified only as Toby at the Texas Center. I asked to be referred to someone in management concerning the medications we had received that day. He asked me to hold while he located a pharmacist. I held for 32 minutes with him coming on the line, (only once) to tell me he was still trying to locate a pharmacist. Finally, a Glenda Oliver answered and then referred my call to someone named Lori. They both expressed concern about the shipment. They said not to use the medicines, even though I believed I could identify them by size, shape and color and replace them in the proper containers. They said a new shipment would be sent that day (February 9, 1996). I suggested they ask for the brand name of the medication to be shown along with the generic name on the label for identifying purposes. They agreed it should be done. They repeatedly thanked me for being pleasant, understanding and having so much patience. They said most people were screaming at them.

On February 9, 1996 another 90-day supply of GEMFIBROZIL and FUROSEMIDE were sent by Federal Express overnight delivery. Our doctor's office did not order this additional supply. Another error was that the FUROSEMIDE (LASIX) was labeled for use by my husband. He has never had this medication prescribed for him.

NAME OF MEDICINE: DYNACIRC, TENORMIN, ZYLOPRIM, GEMFIBROZIL
DATE PROCESSED: February 12, 1996 (originally ordered on January 30, 1996
DATE RECEIVED: February 13, 1996 - by Federal Expres overnight.

PROBLEMS ENCOUNTERED: This one was the duplicate of the order previously sent (see number 2a) and spilled in the package. Again, generic names only were on the labels. This now makes 3 times GEMFIBROZIL has been sent, although ordered only 1 time.

3. NAME OF MEDICINE: CARDIZEM CD, HUMULIN R, and HUMULIN N Insulins, CHEMSTRIPS for BG ACCU-Chek, BD Ultra - Fine Lancets, and BD Ultra - Fine Syringes.
DATE CALLED IN: January 26, 1996
DATE PROCESSED: February 5, 1996
DATE RECEIVED: February 12, 1996 by U.P.S.

PROBLEMS ENCOUNTERED: Called in on January 26, 1996, (after several attempts during the previous week when the nurse could not get through on the line). On January 26th, she was told they

had about 12,000 orders that day. The order was filled on February 2, 1996 but not shipped until February 5, 1996. It was delivered on February 12, 1996 by U.P.S. This was 17 days after the order was placed. The box contained 5 bottles of Insulin, 4 boxes of BG Chemstrips, 4 boxes of BD Lancets, and 360 Insulin syringes and 1 bottle of CARDIZEM CD capsules which comprised a 90-day supply of each item. Also enclosed was 1 Lancet device that had not been ordered. The box containing these supplies was badly damaged with one corner completely ripped open, and inside a box of syringes showed damage to the corner of box. The shipping box appeared to have had unusually rough treatment. I reported the condition of this shipment to a Ms. Jackson at 1-800-262-7890. Her response was that she would report it.

During the period of January 26, 1996 and February 12, 1996 when this order was delivered, I made an inquiry with their pharmacy on how the insulin was being shipped. Following are my questions and their answers:

- Question: Was the insulin being sent refrigerated?
- Answer: No.

- Question: Did they receive the insulin refrigerated?
- Answer: No.

- Question: Was it refrigerated in their warehouse?
- Answer: No.

- Question: Why?
- Answer: It was not necessary. Room temperature was all that was required.

Since I was cautioned that insulin should be refrigerated at all times, but protected from freezing, it caused me great concern. The insulin box says "Keep in a cold place. Avoid freezing."

I called the Eli Lilly Company in Indianapolis, IND. (1-800-545-5979) and posed the question of refrigeration to their pharmacist named Vicki. She said insulin must be kept at 36° - 46° F. or 2° - 8° C. to remain stable. She also stated that there is a federal regulation that requires this. I asked her advice on what could be done about this situation and she said their responsibility was limited to sending it to their distributors under refrigeration. After that the responsibility shifts to other handlers. She suggested the Federal Food and Drug Administration could have some control over this.

I called the F.D.A. in Washington, D.C (1-800-443-3510) and was referred to John Short. I asked him if my concerns were justified because of the variance of year-round temperatures when insulin is being shipped from National Pharmacies in New Jersey to destinations throughout the United States. He said "absolutely, the concern was justified" and showed definite interest in the situation. He thanked me for alerting him to the situation and asked me to call him in a week if I had not heard form him before then.

About 10 days later on February 7, 1996, I again called him and was told he had referred this matter to another department and he had not yet had a report from them. He said he would call me - that reply is still pending.

*** See conclusion on following page. ***

CONCLUSION:

Our conclusion regarding the mail-order system being conducted by National ~~Rx~~ Rx Services is that we are convinced the program embraces too many health risks and too much waste. We cite the following reasons for our opinion:

(1) Health and Welfare of Recipients

(a) The health risks diabetics are subject to when insulin shipments are exposed to fluctuating atmospheric conditions without refrigeration for 10 days, as in my case. When they finally arrived I found it a bit ironic that the insulin bottles bore large warning stickers to "REFRIGERATE UPON ARRIVAL". The warning appeared to be a bit late.

(b) What about the dangers being posed to the health and lives of older citizens, especially those on Medicare, who may not be able to cope with change and with errors being made by an apparently undertrained and over-worked staff of people serving this plan? How could a feeble older man or woman, perhaps living alone, handle medicines with generic names they have never heard of? If they received duplicate orders, as we did, isn't it possible they would take medicine from each bottle they received, thus receiving over-medication? Couldn't thousands of patients become ill if exposed to medicine, especially insulin, if it is improperly handled?

(c) Patients need personal contact with their local pharmacist concerning usage, and for reassurance about their medicines. Compare this system to receiving doctor-care by mail-order.

(2) Prepaid Insurance

(a) Most of us have paid the high cost of constantly rising health insurance premiums to Blue Cross and Blue Shield with lesser costs for Medicare insurance premiums over a large number of years. If waste was tolerated by private insurance companies, as it apparently is in the National Mail Order R/x Service program, they could not stay in business.

(3) Economics of Program

(a) For three orders, one each submitted by our physicians, it required six separate mailings to get the medicines delivered to us. Each one was sent by First Class Priority Mail - Federal Express Overnight, or U.P.S. The one that conceivably should have come by Federal Express took seven days by U.P.S. Multiply the unnecessary costs of the methods by which these orders were shipped, including the duplicate orders, by the thousands of participants and the cost could become staggering.

(b) Why should this business be taken away from private enterprise pharmacies who have educated, trained and qualified pharmacists that have gained the respect, personal contact and trust of their patients and have served them well without the cost of irritating long distance phone calls and mailings. One National Mail Order R/x Service employee informed me there was "no mailing costs because the orders were sent by franked mail". Who do they think pays for it?

We regret the negatism of this report, but it conveys our honest, deep concerned opinions that many corrections and improvements must be made or the health and welfare of thousands of participants are at great risk.

ALFRED WILLIAMS (DECEASED)
ALAN HANSON

WILLIAMS, HANSON, VAN BLARICUM & JORNS
ATTORNEYS AT LAW
P.O. BOX 824 - 126 EAST THIRD
PRATT, KANSAS 67124
TELEPHONE 316-672-9471
FAX 316-672-9473

KENNETH VAN BLARICUM
JANICE J. JORNS

The same letter was sent to Representative Pat Roberts and Senator Robert Dole.

February 15, 1996

Senator Nancy Kassebaum
302 Russell Senate O.B.
Washington, DC 20510

Subject: **Medicare/Insurance Company Forcing Use of Mail Order Pharmacy**

Senator Kassebaum:

My parents are 82 and 83 years old and living in their home in Medicine Lodge. They worked hard, never made a lot of money but paid their bills, taxes and insurance, eventually paying for their home and are now retired living on their social security and little pensions. Age has brought the necessity of medication for various ailments.

Now someone in an ivory tower has decided they must obtain their prescriptions through a mail order system. The service and care by the mail order pharmacy is not, cannot and will not be as good as their hometown pharmacists, who know the patients personally and their doctor. All of the 800 numbers to strange people in strange places and the prepaid postage envelopes with a form to fill out on each one, will not replace the friendly smile and genuine personal interest of their local pharmacist.

When the local doctor can call in a prescription and it can be delivered in five minutes, if necessary, with no strange forms to fill out, there is no way for the mail order pharmacy to compete. At age 82 and 83, phone calls on 800 numbers with an ongoing menu recited by a mechanical voice and/or another form to fill out to mail and wait a week or more for a prescription is not what these kind and gentle people deserve.

The local pharmacist should be able to buy and dispense the needed drugs at competitive prices. If the price per pill is less there will be unused 30 to 90 day supplies wasted. There is no way for the mail order pharmacy to compete with the personal service.

We will expect (or at least we can hope) the pharmacist will still be there to fill that emergency prescription - maybe in the middle of the night. You can call the warehouse pharmacy in New Jersey or Florida on an 800 number and they'll have that prescription to you in a week or maybe ten days or maybe two weeks, unless they have to get "prior approval" then look for three weeks or more.

Ordering drugs through a mail order pharmacy is just one more way to further erode the maintenance of good health care in our rural communities.

Your prompt attention to this matter will be appreciated.

WILLIAMS, HANSON,
VAN BLARICUM & JORNS

Alan Hanson

Alan Hanson
Attorney at Law

AH:rl

xc: Mr. Bob Williams, Executive Director
Kansas Pharmacists Association
1308 West Tenth
Topeka, KS 66604

Mr. John Hagood
Hibbards Healthmart
106 North Main
Medicine Lodge, KS 67104

Mr. and Mrs. Glen Hanson
916 North Walnut
Medicine Lodge, KS 67104

letter/kasbam.ltr

KSNA
KANSAS STATE NURSES ASSOCIATION

700 SW Jackson, Suite 601
Topeka, Kansas 66603-3731

913/233-8638 * FAX 913/233-5222

the Voice of Nursing in Kansas

Betty Smith-Campbell, M.N., R.N., ARNP
President

Terri Roberts, J.D., R.N.
Executive Director

FOR MORE INFORMATION CONTACT
Terri Roberts JD, RN
Executive Director
700 SW Jackson, Suite 601
Topeka, KS 66603-3731
(913) 233-8638
February 21, 1996

H.B. 2985 PROVIDING FOR OUT-OF-NETWORK ACCESS

Representative Bryant and members of the House Financial Institutions and Insurance Committee my name is Debbie Folkerts, ARNP, FNP and I am a family nurse practitioner practicing in Manhattan, Kansas. I am here today on behalf of the Kansas State Nurses Association to support the provisions of H.B. 2985.

There are currently over 1000 ARNP's in the state that deliver health care services. In 1990 and again in 1993 statutory provisions were passed that require health insurers to pay for covered services provided by ARNP's throughout the state. Access to care in rural areas has been facilitated by this provision because ARNP's can staff rural health clinics that maintain viability with the third party reimbursement from the private sector.

The provisions of H.B. 2985 would further access to health care permitting qualified providers to receive partial reimbursement for services performed. It will also serve to level the playing field for provider groups that overlap and provide greater choice to plan beneficiaries.

Thank you.

Debbie Folkerts ARNP, FNP
1808 Little Kitten Ave.
Manhattan, KS 66502
(913) 537-2980

b:96legislation/purple/hb2985/la

House FI&I
Attachment 8
2/21/96

K · A · N · S · A · S

MANAGED HEALTH CARE

ASSOCIATION

February 21, 1996

Chairman Bryant and members of the House Financial Institutions and Insurance Committee:

Thank you for this opportunity to appear here today and provide input on House Bill 2985 on behalf of the Kansas Managed Health Care Association. I am Carole Gates, Legislative Chair for KMHCA and Regional Vice President of Government Affairs for CIGNA.

The Association, having reviewed HB 2985, has the following concerns about this measure:

- HB 2985 is a mandate. It effectively eliminates HMO coverage because it allows all enrollees, regardless of the plan they have, to go outside the network.
- Purchasers who buy group insurance coverage will have no choice as to whether they want to offer this benefit.
- Plans will cost more with the point of service included.
- Mandating 70% reimbursement does not allow flexibility for purchasers who want to keep premiums down.
- Medically "appropriate" appears to be redundant and not a defined policy term. The term medically "necessary" should be substituted or eliminate the section entirely.

Thank you for this opportunity to provide testimony. I would be happy to respond to questions.

House FI&I
Attachment 9
2/21/96

Kansas Employer Coalition on Health, Inc.
214½ S.W. 7th Street, Suite A • Topeka, Kansas 66603
(913) 233-0351 • FAX (913) 233-0384

Testimony to House Financial Institutions and Insurance Committee

on HB 2985

(Providing for out-of-network access)

by James P. Schwartz Jr.
Consulting Director
February 21, 1996

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is nearly 100 employers across Kansas who share concerns about the cost-effectiveness of health care we purchase for a quarter of a million Kansas employees and dependents.

HB 2985 is poor public policy and ought to be rejected.

If our nation operated a health insurance system that required all citizens to buy coverage, all employers to contribute and all providers to abide by fee and utilization restrictions, the argument for prescribing out-of-network coverage would be much stronger.

But we don't have that kind of system, and we don't expect to have it any time soon. Instead we have a voluntary private market, where the volunteers weigh costs and benefits and make hard choices. For some groups the choice boils down to sponsoring either a tightly managed plan or none at all. For others, sponsoring a plan with a closed network of providers simply means value: that group has decided that it would rather take compensation in the form of higher wages and other benefits--rather than in the form of more liberal health insurance. Yes, employers ultimately make those decisions on behalf of their employees, but they do so knowing that their benefit package must compete with those of other employment opportunities. In other words, the employer is always maximizing apparent value of employee health benefits. And it would be a disservice to that voluntary market for government to intervene and dictate terms. Remember, employers sponsor health insurance to attract employees and keep them happy. If employees are unhappy with network access, the employer is highly motivated to do something about it.

House FI&I
Attachment 10
2/21/96

Managed care is succeeding in holding down healthcare costs. According to the US Chamber of Commerce, the cost of employee health benefits in 1994 fell 9.5%--a dramatic reversal of two decades of soaring costs. The key reason, researchers found, was the increased percentage of firms offering HMO plans. In most companies, the conversion to managed care has been accepted rather well by employees. Notwithstanding some isolated accounts of miscues, employee satisfaction with HMOs remains high. The message has been rather well received: open access bears a cost, a cost that most citizens are no longer willing to pay, especially when they understand that such costs rob them of their next pay raise.

So who is most unhappy with restricted access? Of course the answer is: those providers who are losing business in the managed care environment. Those providers need to appreciate that by appealing for governmental regulation as a replacement for the invisible hand of managed care, they embark on a course that ultimately surrenders their autonomy.

Finally, some may argue that there's no harm in having groups offer POS plans alongside HMOs, as long as the employee contribution to premium reflects the excess cost. The problem with this argument is that administering a more complex benefit plan bears a cost, too, especially for smaller companies. In the future, healthplan purchasing cooperatives will efficiently provide the kind of choice that proponents of HB 2985 seek. Until those cooperatives are established, though, forcing groups to bear the cost of expanded choice is a poor role for government.

MEMORANDUM

TO: The Honorable Bill Bryant, Chairman
House Financial Institutions and Insurance Committee

FROM: William W. Sneed, Legislative Counsel
Health Insurance Association of America

DATE: February 21, 1996

RE: HB 2985

Mr. Chairman and Members of the Committee: My name is Bill Sneed and I represent the Health Insurance Association of America (HIAA). HIAA is a group of over 300 private insurance companies which write approximately 80% of the health insurance coverage in the United States today. We appreciate this opportunity to present testimony in opposition to H.B. 2985.

House Bill 2985 prohibits insurance companies and health maintenance organizations from limiting insureds' access to covered treatment out-of-network, and requires that insurers pay a 70% benefit for covered out-of-network services which are medically appropriate. HIAA opposes the creation of the 70% mandated benefit. Provider networks are specifically utilized to lower the cost of health care for those insureds in the plan. To keep costs down, insureds receive financial incentives to seek services within the network. This legislation to some degree erodes the financial incentives put in place by insurance companies and HMOs to keep health care costs down. The mandated benefit will instead increase the cost of medical care in Kansas.

Further, market forces adequately control the differential between in and out-of-network coverage. Insurers and HMOs must maintain the differential at competitive levels to remain in business. State-mandated benefit levels serve only to impose unnecessary government control where it is not needed.

Feb. 21, 1996
Attachment 11

Finally, as with all mandated benefits, this legislation would only apply to approximately 40% of Kansas insureds. Nearly 60% of Kansas insureds are covered by ERISA plans not affected by state law. The 40% that are affected will shoulder the higher health care costs that mandates necessarily bring.

In sum, HIAA opposes H.B. 2985 because it thwarts the cost-saving incentive offered by insurers to utilize in-network services, in turn driving up health care costs. The mandate will not apply to a good share of Kansas insureds, leaving the rest to carry the burden of increased health care costs. Thus, we respectfully request your disfavorable action on H.B. 2985.

Thank you for the opportunity to present our testimony. Please feel free to contact me if you have any questions.

Respectfully submitted,

William W. Sneed

11-2

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

835 SW Topeka Blvd. Topeka, Kansas 66612-1671 (913) 357-6321 FAX (913) 357-4732

HB 2985 February 21, 1996

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Financial Institutions and Insurance

by
Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

My name is Terry Leatherman. I am the Executive Director of the Kansas Industrial Council, a division of the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to comment on HB 2985.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

As this Committee clearly understands, there are a couple of basic truths about health insurance in Kansas. Employers play a crucial role in the delivery of health insurance to Kansans, and economics is a major factor in an employer's decision on the level of participation in an employee health insurance plan. In recent years, some of the most successful approaches to

House FI&I
Attachment 12
2/21/96

ining health insurance costs have involved negotiating cost containment with a network of health care providers.

KCCI's concern with HB 2985 is how it might reverse these efforts to control health insurance costs. If negotiated fees are lost because exclusivity has been compromised, then the net effect of HB 2985 might be higher insurance costs and more Kansans joining the roster of the state's uninsured population.

As a result, the Kansas Chamber would urge this Committee not to advance legislation which might adversely affect the cost of health insurance in our state. Thank you for this chance to comment on HB 2985. I would be happy to attempt to answer any questions.

BRAD SMOOT
ATTORNEY AT LAW

EIG[illegible] JACKSON STREET
ME[illegible] ILE BANK BUILDING
SU[illegible] 8
TOP[illegible], KANSAS 66612
(913) 233-0016
(913) 234-3687 FAX

10200 STAT[illegible]E ROAD
SUITE 230
LEAWOOD, KANSAS 66206
(913) 649-6836

Testimony Of Brad Smoot, Legislative Counsel Blue Cross Blue Shield Of Kansas Regarding House Bill 2985 Before House Financial Institutions And Insurance Committee February 21, 1996

I am Brad Smoot, legislative counsel for Blue Cross Blue Shield of Kansas, a domestic health insurer providing coverage for more than 700,000 Kansans in 103 counties of the state.

Blue Cross and Blue Shield of Kansas has an affiliated health maintenance organization, Premier Blue, which has been operational since last summer.

Coverage under Premier Blue requires members to obtain services from, or upon referral by, a primary care physician designated by the member. The purpose of this is to allow for total management of a patient's care. For many years, most persons have recognized that physician orders for services generate the bulk of dollars spent on health care, including hospital care, drugs, and specialist care. Allowing a single primary care physician to manage all of a patient's care assures that duplicate tests are not ordered, that unneeded services are not provided merely upon patient demand, and equally important, that preventive services are provided in the first place to avoid later incursions of costs.

Premier Blue has some exceptions to the need to seek care from or upon referral by a primary care physician. In particular, it has a "well-woman benefit" that permits female members to obtain certain OB/Gyn services from any OB/Gyn contracting with Premier Blue directly, rather than having to go through the primary care physician for a referral.

Because of the management of total patient care, Premier Blue costs less than do our health insurance programs that provide benefits on an open-panel, unrestricted basis.

There are, however, both employers and employees who like the opportunity to obtain services directly from providers of their choosing on occasion, rather than going through a PCP. Some employers realize that not all employees will be comfortable with an HMO, are hesitant to purchase only HMO coverage.

To meet this marketplace demand, Blue Cross sells, in conjunction with Premier Blue, a "wraparound" product, or "self-referral option". Under it, Blue Cross provides benefits if a person holding Premier Blue coverage "self-refers" rather than going through that person's primary care physician for care or for a referral. An additional, separate deductible and coinsurance is associated with coverage obtained on a self-referred basis; if there were not, there would be no incentive for members ever to use their primary care physicians.

House FI&I
Attachment 13
2/21/96

Although sales of Premier Blue are relatively new, there are currently 159 groups which have Premier Blue only, and 25 which have Premier Blue with the self-referral option allowing benefits for direct access to out-of-network providers. In terms of numbers of employees, 16,968 (60.9% of Premier Blue enrollment) have Premier Blue exclusively, and 9,934 (39.1%) have Premier Blue with a self-referral option.

The reason employers and employees choose Premier Blue only, rather than Premier Blue with the self-referral option, is obviously to save costs. Below is a table comaring costs for Premier Blue standing alone (labelled "HMO" in the rate box) and Premier Blue with the self-referral option (labelled "SRO").

The point of this is that employers and employees have available to them a lot of choices in the marketplace, including traditional insurance, HMOs, and point-of-service programs such as an HMO with a self-referral benefit, which allows benefits for services obtained from an out-of-network provider. To require all coverage to include a benefit for services obtained from an out-of-network provider would rob employers of choices in a highly competitive marketplace, force all benefit programs into a cookie-cutter mold, and increase costs to employers and employees (the example illustrates a rate for self-referral benefits more than 50% higher than the rate for HMO exclusive benefits).

PremierBlue

Comparison of Plan 1 and Plan 51

		Plan 1	Plan 51
Benefits			
Primary	Inpatient	$50 Copay (max 3/6 days)	$50 Copay (max 3/6 days)
	Professional	$10 Office Visit Copay	$10 Office Visit Copay
	Emergency Room	$50 Copay	$50 Copay
SRO		None	$200 Deductible 50/50 Coinsurance ($1000 max)
Rate			
Four Tier	Employee	$149.36	$161.25
	Employee/Child(ren)	$285.28	$308.00
	Employee/Spouse	$321.12	$346.71
	Employee/Dependents	$314.58	$493.42
		(HMO)	(SRO)
Ratio of Plan 51 to Plan 1			
	Employee	1.08	
	Employee/Child(ren)	1.08	
	Employee/Spouse	1.08	
	Employee/Dependents	1.08	

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Ka City, Missouri
64131-3471
(816) 941-8900

February 21, 1996

Humana® Health Care Plans

TESTIMONY ON KANSAS HOUSE BILL NO. 2985

It is not correct that HMOs simply manage costs. They manage care. Not every physician can be an HMO doctor. That is not to say they are bad doctors. But there are certain skills, abilities and mind-sets that HMO doctors must have to practice managed care. The point is that managed care is a style of practice, not just a business. These skills include:

1. Learning to function as a primary care physician. Specialists need to learn how to work with primary care physicians.

2. Learning to work as a member of a coordinated team to provide care to members. HMOs have established integrated systems to arrange for and provide care to patients in less costly settings. Network physicians work well with these systems. Out-of-network doctors do not.

3. Learning to use outcomes based empirical guidelines.

4. Learning to use a sequential approach based on probabilities for outpatient diagnosis, rather than the shotgun approach most physicians learn in their training.

Developing a network of physicians trained in these and other skills and others requires a large investment of time and effort. Allowing members to use out-of-network physicians undermines this effort.

The additional costs associated with out-of-network use exceeds the 30% difference between what is considered reasonable and what is actually paid. Most HMOs pay their physicians on a capitation basis. Paying for members to go out-of-network means that the HMOs are paying twice for the same service. In addition, there are utilization questions associated with the use of non-plan physicians, as well as additional costs associated with tests and procedures ordered from other out-of-network providers. Thus, this bill has the potential to greatly raise the cost of providing health care to HMO members.

House F I & L
Attachment 14
Feb. 21, 1996

HMOs, by their very nature, involve coordination of care. This coordination becomes difficult, if not impossible, when members go out-of-network. Continuity of care may suffer, leading to a reduction in the overall quality of medical care.

Thank you for the opportunity to address this bill.

Bruce Barter, MD

Bruce Barter, M.D.
Humana Health Care Plans

HOUSE BILL No. 2691

By Representative Empson

1-19

AN ACT relating to motor vehicles; concerning financial security requirements; amending K.S.A. 8-1604 and 40-3118 and K.S.A. 1995 Supp. 40-3104 and repealing the existing sections.

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

Section 1. K.S.A. 8-1604 is hereby amended to read as follows: 8-1604. (a) The driver of any vehicle involved in an accident resulting in injury to or death of any person, or damage to any vehicle or other property which is driven or attended by any person, shall give such person's name, address and the registration number of the vehicle such person is driving, and upon request shall exhibit such person's license or permit to drive, the name of the company with which there is in effect a policy of motor vehicle liability insurance covering the vehicle involved in the accident and the policy number of such policy to any person injured in such accident or to the driver or occupant of or person attending any vehicle or other property damaged in such accident, and shall give such information and upon request exhibit such license or permit and the name of the insurer and policy number, to any police officer at the scene of the accident or who is investigating the accident and shall render to any person injured in such accident reasonable assistance, including the carrying, or the making of arrangements for the carrying of such person to a physician, surgeon or hospital for medical or surgical treatment if it is apparent that such treatment is necessary, or if such carrying is requested by the injured person.

(b) In the event that none of the persons specified are in condition to receive the information to which they otherwise would be entitled under subsection (a) of this section, and no police officer is present, the driver of any vehicle involved in such accident after fulfilling all other requirements of K.S.A. 8-1602, and amendments thereto, and subsection (a) of this section, insofar as possible on such person's part to be performed, shall forthwith report such accident to the nearest office of a duly authorized police authority and submit thereto the information specified in subsection (a) of this section.

(c) Unless the insurance company subsequently submits an insurance verification form indicating that insurance was not in force, no person

House F.I. & I.
Attachment #15
2/21/96

charged with failing to provide the name of such person's insurance company and policy number as required in subsection (a), shall be convicted if such person produces in court, within ~~20~~ *10* days of the date of arrest or of issuance of the citation, evidence of financial security for the motor vehicle operated, which was valid at the time of arrest or of issuance of the citation. For the purpose of this subsection, evidence of financial security shall be provided by a policy of motor vehicle liability insurance, an identification card or certificate of insurance issued to the policyholder by the insurer which provides the name of the insurer, the policy number, make and year of the vehicle and the effective and expiration dates of the policy, or a certificate of self-insurance signed by the commissioner of insurance. Upon the production in court of evidence of financial security, the court shall record the information displayed thereon on the insurance verification form prescribed by the secretary of revenue, immediately forward such form to the department of revenue, and stay any further proceedings on the matter pending a request from the prosecuting attorney that the matter be set for trial. Upon receipt of such form the department shall mail the form to the named insurance company for verification that insurance was in force on the date indicated on the form. It shall be the duty of insurance companies to notify the department within 30 calendar days of the receipt of such forms of any insurance that was not in force on the date specified. Upon return of any form to the department indicating that insurance was not in force on such date, the department shall immediately forward a copy of such form to the office of the prosecuting attorney or the city clerk of the municipality in which such prosecution is pending when the prosecuting attorney is not ascertainable. Receipt of any completed form indicating that insurance was not in effect on the date specified shall be prima facie evidence of failure to provide proof of financial security and violation of this section. A request that the matter be set for trial shall be made immediately following the receipt by the prosecuting attorney of a copy of the form from the department of revenue indicating that insurance was not in force Any charge hereunder shall be dismissed if no request for a trial setting has been made within 60 days of the date evidence of financial security was produced in court.

Sec. 2. K.S.A. 1995 Supp. 40-3104 is hereby amended to read as follows: 40-3104. (a) Every owner shall provide motor vehicle liability insurance coverage in accordance with the provisions of this act for every motor vehicle owned by such person, unless such motor vehicle: (1) Is included under an approved self-insurance plan as provided in subsection (f); (2) is used as a driver training motor vehicle, as defined in K.S.A. 72-5015, and amendments thereto, in an approved driver training course by a school district or an accredited nonpublic school under an agreement with a motor vehicle dealer, and such motor vehicle liability insurance

15-2

coverage is provided by the school district or accredited nonpublic school; (3) is included under a qualified plan of self-insurance approved by an agency of the state in which such motor vehicle is registered and the form prescribed in subsection (b) of K.S.A. 40-3106, and amendments thereto, has been filed; or (4) is expressly exempted from the provisions of this act.

(b) An owner of an uninsured motor vehicle shall not permit the operation thereof upon a highway or upon property open to use by the public, unless such motor vehicle is expressly exempted from the provisions of this act.

(c) No person shall knowingly drive an uninsured motor vehicle upon a highway or upon property open to use by the public, unless such motor vehicle is expressly exempted from the provisions of this act.

(d) Any person operating a motor vehicle upon a highway or upon property open to use by the public shall display, upon demand, evidence of financial security to a law enforcement officer. The law enforcement officer shall issue a citation to any person who fails to display evidence of financial security upon such demand. The law enforcement officer shall attach a copy of the insurance verification form prescribed by the secretary of revenue to the copy of the citation forwarded to the court.

No citation shall be issued to any person for failure to provide proof of financial security when evidence of financial security meeting the standards of subsection (e) is displayed upon demand of a law enforcement officer. Whenever the authenticity of such evidence is questionable, the law enforcement officer may initiate the preparation of the insurance verification form prescribed by the secretary of revenue by recording information from the evidence of financial security displayed. The officer shall immediately forward the form to the department of revenue, and the department shall proceed with verification in the manner prescribed in the following paragraph. Upon return of a form indicating that insurance was not in force on the date indicated on the form, the department shall immediately forward a copy of the form to the law enforcement officer initiating preparation of the form.

(e) Unless the insurance company subsequently submits an insurance verification form indicating that insurance was not in force, no person charged with violating subsections (b), (c) or (d) shall be convicted if such person produces in court, within ~~20~~ *10* days of the date of arrest or of issuance of the citation, evidence of financial security for the motor vehicle operated, which was valid at the time of arrest or of issuance of the citation. For the purpose of this subsection, evidence of financial security shall be provided by a policy of motor vehicle liability insurance, an identification card or certificate of insurance issued to the policyholder by the insurer which provides the name of the insurer, the policy number and

15-3

the effective and expiration dates of the policy, or a certificate of self-insurance signed by the commissioner of insurance. Upon the production in court of evidence of financial security, the court shall record the information displayed thereon on the insurance verification form prescribed by the secretary of revenue, immediately forward such form to the department of revenue, and stay any further proceedings on the matter pending a request from the prosecuting attorney that the matter be set for trial. Upon receipt of such form the department shall mail the form to the named insurance company for verification that insurance was in force on the date indicated on the form. It shall be the duty of insurance companies to notify the department within 30 calendar days of the receipt of such forms of any insurance that was not in force on the date specified. Upon return of any form to the department indicating that insurance was not in force on such date, the department shall immediately forward a copy of such form to the office of the prosecuting attorney or the city clerk of the municipality in which such prosecution is pending when the prosecuting attorney is not ascertainable. Receipt of any completed form indicating that insurance was not in effect on the date specified shall be prima facie evidence of failure to provide proof of financial security and violation of this section. A request that the matter be set for trial shall be made immediately following the receipt by the prosecuting attorney of a copy of the form from the department of revenue indicating that insurance was not in force. Any charge of violating subsection (b), (c) or (d) shall be dismissed if no request for a trial setting has been made within 60 days of the date evidence of financial security was produced in court.

(f) Any person in whose name more than 25 motor vehicles are registered in Kansas may qualify as a self-insurer by obtaining a certificate of self-insurance from the commissioner of insurance. The certificate of self-insurance issued by the commissioner shall cover such owned vehicles and those vehicles, registered in Kansas, leased to such person if the lease agreement requires that motor vehicle liability insurance on the vehicles be provided by the lessee. Upon application of any such person, the commissioner of insurance may issue a certificate of self-insurance, if the commissioner is satisfied that such person is possessed and will continue to be possessed of ability to pay any judgment obtained against such person arising out of the ownership, operation, maintenance or use of any motor vehicle described in this subsection.

Upon notice and a hearing in accordance with the provisions of the Kansas administrative procedure act, the commissioner of insurance may cancel a certificate of self-insurance upon reasonable grounds. Failure to pay any judgment against a self-insurer, arising out of the ownership, operation, maintenance or use of a motor vehicle registered in such self-insurer's name, within 30 days after such judgment shall have become

154

15-5

final, shall constitute reasonable grounds for the cancellation of a certificate of self-insurance.

(g) (1) Any person violating any provision of this section shall be guilty of a class B misdemeanor and shall be subject to a fine of not less than $200 nor more than $1,000 or confinement in the county jail for a term of not more than six months, or both such fine and confinement.

(2) Any person convicted of violating any provision of this section within three years of any such prior conviction shall be guilty of a class A misdemeanor.

(h) In addition to any other penalties provided by this act for failure to have or maintain financial security in effect, the director, upon receipt of a report required by K.S.A. 8-1607 or 8-1611, and amendments thereto, or a denial of such insurance by the insurance company listed on the form prescribed by the secretary of revenue pursuant to subsection (d) of this section, shall, upon notice and hearing as provided by K.S.A. 40-3118, and amendments thereto, suspend:

~~(1)~~ The license of each driver in any manner involved in the accident;

~~(2)~~ the license of the owner of each motor vehicle involved in such accident, unless the vehicle was stolen at the time of the accident, proof of which must be established by the owner of the motor vehicle. Theft by a member of the vehicle owner's immediate family under the age of 18 years shall not constitute a stolen vehicle for the purposes of this section;

~~(3) the registrations of all vehicles owned by the owner of each motor vehicle involved in such accident;~~

~~(4)~~ if the driver is a nonresident, the privilege of operating a motor vehicle within this state; or

~~(5)~~ if such owner is a nonresident, the privilege of such owner to operate or permit the operation within this state of any motor vehicle owned by such owner;

(i) The suspension requirements in subsection (h) shall not apply:

(1) To the driver or owner if the owner had in effect at the time of the accident an automobile liability policy as required by K.S.A. 40-3107, and amendments thereto, with respect to the vehicle involved in the accident;

(2) to the driver, if not the owner of the vehicle involved in the accident, if there was in effect at the time of the accident an automobile liability policy with respect to such driver's driving of vehicles not owned by such driver;

(3) to any self-insurer as defined by subsection (u) of K.S.A. 40-3103, and amendments thereto;

(4) to the driver or owner of any vehicle involved in the accident which was exempt from the provisions of this act pursuant to K.S.A. 40-

(1)

(A)

(B)

(C)

(D)

; or (2) revoke the registration of all vehicles owned by the owner of each motor vehicle involved in such accident.

or revocation

3105, and amendments thereto;

(5) to the owner of a vehicle described in subsection (a)(2).

(j) For the purposes of provisions (1) and (2) of subsection (i) of this section, the director may require verification by an owner's or driver's insurance company or agent thereof that there was in effect at the time of the accident an automobile liability policy as required in this act.

Any suspension effected hereunder shall remain in effect until satisfactory proof of financial security has been filed with the director as required by subsection (d) of K.S.A. 40-3118, and amendments thereto, and such person has been released from liability or is a party to an action to determine liability pursuant to which the court temporarily stays such suspension pending final disposition of such action~~, has entered into an agreement for the payment of damages,~~ or has been finally adjudicated not to be liable in respect to such accident and evidence of any such fact has been filed with the director and has paid the reinstatement fee herein prescribed. Such reinstatement fee shall be $25 except that if the registration of a motor vehicle of any owner is ~~suspended~~ within one year following a prior ~~suspension~~ of the registration of a motor vehicle of such owner under the provisions of this act such fee shall be $75.

or revocation

, has entered into an agreement for the payment of damages

revoked

revocation

(k) The provisions of this section shall not apply to motor carriers of property or passengers regulated by the corporation commission of the state of Kansas.

(l) The provisions of subsection (d) shall not apply to vehicle dealers, as defined in K.S.A. 8-2401, and amendments thereto, for vehicles being offered for sale by such dealers.

Sec. 3. K.S.A. 40-3118 is hereby amended to read as follows: 40-3118. (a) No motor vehicle shall be registered or reregistered in this state unless the owner, at the time of registration, has in effect a policy of motor vehicle liability insurance covering such motor vehicle, as provided in this act, or is a self-insurer thereof, or the motor vehicle is used as a driver training motor vehicle, as defined in K.S.A. 72-5015, and amendments thereto, in an approved driver training course by a school district or an accredited nonpublic school under an agreement with a motor vehicle dealer, and such policy of motor vehicle liability insurance is provided by the school district or accredited nonpublic school. As used in this section, the term "financial security" means such policy or self-insurance. The director shall require that the owner certify that the owner has such financial security, and the owner of each motor vehicle registered in this state shall maintain financial security continuously throughout the period of registration. When an owner certifies that such financial security is a motor vehicle liability insurance policy meeting the requirements of this act, the director may require that the owner or owner's insurance company produce records to prove the fact that such insurance was in

effect at the time the vehicle was registered and has been maintained continuously from that date. Failure to produce such records shall be prima facie evidence that no financial security exists with regard to the vehicle concerned. It shall be the duty of insurance companies, upon the request of the director, to notify the director within 30 calendar days of the date of the receipt of such request by the director of any insurance that was not in effect on the date of registration and maintained continuously from that date.

(b) Except as otherwise provided in K.S.A. 40-276, 40-276a and 40-277, and amendments thereto, and except for termination of insurance resulting from nonpayment of premium or upon the request for cancellation by the insured, no motor vehicle liability insurance policy, or any renewal thereof, shall be terminated by cancellation or failure to renew by the insurer until at least 30 days after mailing a notice of termination, by certified or registered mail or United States post office certificate of mailing, to the named insured at the latest address filed with the insurer by or on behalf of the insured. Time of the effective date and hour of termination stated in the notice shall become the end of the policy period. Every such notice of termination sent to the insured for any cause whatsoever shall include on the face of the notice a statement that financial security for every motor vehicle covered by the policy is required to be maintained continuously throughout the registration period, that the operation of any such motor vehicle without maintaining continuous financial security therefor is a class B misdemeanor and that the registration for any such motor vehicle for which continuous financial security is not provided is subject to suspension and the driver's license of the owner thereof is subject to suspension.

(c) The director of vehicles shall verify a sufficient number of insurance certifications each calendar year as the director deems necessary to insure compliance with the provisions of this act. The owner or owner's insurance company shall verify the accuracy of any owner's certification upon request, as provided in subsection (a).

(d) In addition to any other requirements of this act, the director shall require a person to acquire insurance and for such person's insurance company to maintain on file with the division evidence of such insurance for a period of ~~three years from the date such person's driving privileges are otherwise eligible to be reinstated after such~~ one year when a person has been convicted in this or another state of any of the ~~following~~ violations enumerated in K.S.A. 8-285, and amendments thereto:

~~(1) Vehicular homicide, as defined by K.S.A. 21-3405 and amendments~~ thereto, or as prohibited by any ordinance of any ~~city in this~~ state or any law of another state which is in ~~substantial~~ conformity with that statute;

(2) violating K.S.A. 8-1567 and amendments thereto, or violating an ~~ordinance of any city in this state or any law of another state, which~~

15-1

~~ordinance or law declares to be unlawful the acts prohibited by that statute;~~

(3) driving while the privilege to operate a motor vehicle on the public highways of this state has been canceled, suspended ~~or~~ revoked, as prohibited by K.S.A. 8-262 and amendments thereto, ~~or~~ as prohibited by any ordinance of any city in this state or any law of another state which is in substantial conformity with that statute;

(4) any crime punishable as a ~~felony~~, if a motor vehicle was used in the perpetration of the crime;

(5) failing to stop at the scene of an accident and perform the duties required by K.S.A. 8-1602 through 8-1604, and amendments thereto, or required by any ordinance of any city in this state or a law of another state which is in substantial conformity with those statutes; and

(6) violating the provisions of K.S.A. 40-3104 and amendments thereto, relating to motor vehicle liability insurance coverage or an ordinance of any city in this state which is in substantial conformity with ~~such statute~~.

The director shall also require any driver whose driving privileges have been suspended pursuant to this section ~~or K.S.A. 40-3104 and amendments thereto~~ to maintain such evidence of insurance as required above.

The company of the insured shall immediately mail notice to the director whenever any policy required by this subsection to be on file with the division is terminated by the insured or the insurer for any reason. The receipt by the director of such termination shall be prima facie evidence that no financial security exists with regard to the person concerned.

No cancellation notice shall be sent to the director if the insured adds or deletes a vehicle, adds or deletes a driver, renews a policy or is issued a new policy by the same company. No cancellation notice shall be sent to the director prior to the date the policy is terminated if the company allows a grace period for payment until such grace period has expired and the policy is actually terminated.

For the purposes of this act, the term "conviction" includes pleading guilty or *nolo contendere*, being convicted or being found guilty of any violation enumerated in this subsection without regard to whether sentence was suspended or probation granted. A forfeiture of bail, bond or collateral deposited to secure a defendant's appearance in court, which forfeiture has not been vacated, shall be equivalent to a conviction. ~~Also entering into a diversion agreement in lieu of further criminal proceedings on a complaint alleging a violation of the offense described in paragraph (2) of this subsection shall constitute a conviction for the purpose of this act.~~

The requirements of this subsection shall apply whether or not such person owns a motor vehicle.

(e) Whenever the director shall receive prima facie evidence, as prescribed by this section, that continuous financial security covering any motor vehicle registered in this state is not in effect, the director shall notify the owner by registered or certified mail or United States post office certificate of mailing that, at the end of 30 days after the notice is

15-8

mailed, the registration for such motor vehicle and the driving privileges of the owner of the vehicle shall be suspended pursuant to such rules and regulations as the secretary of revenue shall adopt, unless *within 10 days after the notice is mailed*: (1) ~~Within the thirty-day period,~~ Such owner shall demonstrate proof of continuous financial security covering such vehicle to the satisfaction of the director; or (2) ~~within the thirty-day period~~ such owner shall *mail a written* request *which is postmarked within 10 days after the notice is mailed requesting* a hearing with the director. Upon receipt of a timely request for a hearing, the director shall afford such person an opportunity for hearing within the time and in the manner provided in K.S.A. 8-255 and amendments thereto. If, within the ~~thirty-day~~ *ten-day* period or at the hearing, such owner is unable to demonstrate proof of continuous financial security covering the motor vehicle in question, the director shall ~~suspend~~ the registration of such motor vehicle and the driving privileges of the owner of the vehicle, ~~unless the failure is due to a cause beyond the reasonable control of the owner upon proof deemed satisfactory by the director~~.

(f) Whenever the registration of a motor vehicle or the driving privileges of the owner of the vehicle are suspended for failure of the owner to maintain continuous financial security, such suspension shall remain in effect until satisfactory proof of insurance has been filed with the director as required by subsection (d) and a reinstatement fee in the amount herein prescribed is paid to the division of vehicles. Such reinstatement fee shall be in the amount of $25 except that if the registration of a motor vehicle of any owner is ~~suspended~~ within one year following a prior ~~suspension~~ of the registration of a motor vehicle of such owner under the provisions of this act such fee shall be in the amount of $75. The division of vehicles shall, at least monthly, deposit such fees with the state treasurer, who shall credit such moneys to the state highway fund.

(g) In no case shall any motor vehicle, the registration of which has been ~~suspended~~ for failure to have continuous financial security, be reregistered in the name of the owner thereof, the owner's spouse, parent or child or any member of the same household, until the owner complies with subsection (f). In the event the registration plate has expired, no new plate shall be issued until the motor vehicle owner complies with the reinstatement requirements as required by this act.

(h) Evidence that an owner of a motor vehicle, registered or required to be registered in this state, has operated or permitted such motor vehicle to be operated in this state without having in force and effect the financial security required by this act for such vehicle, together with proof of records of the division of vehicles indicating that the owner did not have such financial security, shall be prima facie evidence that the owner did at the time and place alleged, operate or permit such motor vehicle

or revoked

revoke

suspend

or revoked

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revoked

revocation

revoked

15-9

to be operated without having in full force and effect financial security required by the provisions of this act.

(i) Any owner of a motor vehicle registered or required to be registered in this state who shall make a false certification concerning financial security for the operation of such motor vehicle as required by this act, shall be guilty of a class ~~B~~ misdemeanor. Any person, firm or corporation giving false information to the director concerning another's financial security for the operation of a motor vehicle registered or required to be registered in this state, knowing or having reason to believe that such information is false, shall be guilty of a class ~~B~~ misdemeanor.

A

A

(j) The director shall administer and enforce the provisions of this act relating to the registration of motor vehicles, and the secretary of revenue shall adopt such rules and regulations as may be necessary for its administration.

(k) Whenever any person has made application for insurance coverage and such applicant has submitted payment or partial payment with such application, the insurance company, if payment accompanied the application and if insurance coverage is denied, shall refund the unearned portion of the payment to the applicant or agent with the notice of denial of coverage. If payment did not accompany the application to the insurance company but was made to the agent, the agent shall refund the unearned portion of the payment to the applicant upon receipt of the company's notice of denial.

(l) For the purpose of this act, "declination of insurance coverage" means a final denial, in whole or in part, by an insurance company or agent of requested insurance coverage.

Sec. 4. K.S.A. 8-1604 and 40-3118 and K.S.A. 1995 Supp. 40-3104 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

15-10

PROPOSED AMENDMENT

Section 1. K.S.A. 1995 Supp. 40-3104 is hereby amended to read as follows: 40-3104. (a) Every owner shall provide motor vehicle liability insurance coverage in accordance with the provisions of this act for every motor vehicle owned by such person, unless such motor vehicle: (1) Is included under an approved self-insurance plan as provided in subsection (f); (2) is used as a driver training motor vehicle, as defined in K.S.A. 72-5015, and amendments thereto, in an approved driver training course by a school district or an accredited nonpublic school under an agreement with a motor vehicle dealer, and such motor vehicle liability insurance coverage is provided by the school district or accredited nonpublic school; (3) is included under a qualified plan of self-insurance approved by an agency of the state in which such motor vehicle is registered and the form prescribed in subsection (b) of K.S.A. 40-3106, and amendments thereto, has been filed; or (4) is expressly exempted from the provisions of this act.

(b) An owner of an uninsured motor vehicle shall not permit the operation thereof upon a highway or upon property open to use by the public, unless such motor vehicle is expressly exempted from the provisions of this act.

(c) No person shall knowingly drive an uninsured motor vehicle upon a highway or upon property open to use by the public, unless such motor vehicle is expressly exempted from the provisions of this act.

(d) Any person operating a motor vehicle upon a highway or upon property open to use by the public shall display, upon demand, evidence of financial security to a law enforcement officer. The law enforcement officer shall issue a citation to any person who fails to display evidence of financial security upon such demand. The law enforcement officer shall attach a copy of the insurance verification form prescribed by the secretary of revenue to the copy of the citation forwarded to the court.

House F&D
Attachment 16
Feb. 21, 1996

No citation shall be issued to any person for failure to provide proof of financial security when evidence of financial security meeting the standards of subsection (e) is displayed upon demand of a law enforcement officer. Whenever the authenticity of such evidence is questionable, the law enforcement officer may initiate the preparation of the insurance verification form prescribed by the secretary of revenue by recording information from the evidence of financial security displayed. The officer shall immediately forward the form to the department of revenue, and the department shall proceed with verification in the manner prescribed in the following paragraph. Upon return of a form indicating that insurance was not in force on the date indicated on the form, the department shall immediately forward a copy of the form to the law enforcement officer initiating preparation of the form.

(e) Unless the insurance company subsequently submits an insurance verification form indicating that insurance was not in force, no person charged with violating subsections (b), (c) or (d) shall be convicted if such person produces in court, within 20 days of the date of arrest or of issuance of the citation, evidence of financial security for the motor vehicle operated, which was valid at the time of arrest or of issuance of the citation. For the purpose of this subsection, evidence of financial security shall be provided by a policy of motor vehicle liability insurance, an identification card or certificate of insurance issued to the policyholder by the insurer which provides the name of the insurer, the policy number and the effective and expiration dates of the policy, or a certificate of self-insurance signed by the commissioner of insurance. Upon the production in court of evidence of financial security, the court shall record the information displayed thereon on the insurance verification form prescribed by the secretary of revenue, immediately forward such form to the department of revenue, and stay any further proceedings on the matter pending a request from the prosecuting attorney that the matter be set for trial. Upon

receipt of such form the department shall mail the form to the named insurance company for verification that insurance was in force on the date indicated on the form. It shall be the duty of insurance companies to notify the department within 30 calendar days of the receipt of such forms of any insurance that was not in force on the date specified. Upon return of any form to the department indicating that insurance was not in force on such date, the department shall immediately forward a copy of such form to the office of the prosecuting attorney or the city clerk of the municipality in which such prosecution is pending when the prosecuting attorney is not ascertainable. Receipt of any completed form indicating that insurance was not in effect on the date specified shall be prima facie evidence of failure to provide proof of financial security and violation of this section. A request that the matter be set for trial shall be made immediately following the receipt by the prosecuting attorney of a copy of the form from the department of revenue indicating that insurance was not in force. Any charge of violating subsection (b), (c) or (d) shall be dismissed if no request for a trial setting has been made within 60 days of the date evidence of financial security was produced in court.

(f) Any person in whose name more than 25 motor vehicles are registered in Kansas may qualify as a self-insurer by obtaining a certificate of self-insurance from the commissioner of insurance. The certificate of self-insurance issued by the commissioner shall cover such owned vehicles and those vehicles, registered in Kansas, leased to such person if the lease agreement requires that motor vehicle liability insurance on the vehicles be provided by the lessee. Upon application of any such person, the commissioner of insurance may issue a certificate of self-insurance, if the commissioner is satisfied that such person is possessed and will continue to be possessed of ability to pay any ~~judgment obtained~~ liability imposed by law against such person arising out of the ownership, operation, maintenance or use of any motor vehicle described in this subsection. A

self-insurer shall provide liability protection subject to the provisions of subsection (e) of K.S.A. 40-3107, and amendments thereto, arising out of the ownership, operation, maintenance or use of a self-insured motor vehicle in those instances where the lessee or the rental driver, if not the lessee, does not have a motor vehicle liability insurance policy or insurance coverage pursuant to a motor vehicle liability insurance policy or certificate of insurance or such insurance policy for such leased or rented vehicle. Such liability coverage shall be provided to any person operating a self-insured motor vehicle with the expressed or implied consent of the self-insurer.

Upon notice and a hearing in accordance with the provisions of the Kansas administrative procedure act, the commissioner of insurance may cancel a certificate of self-insurance upon reasonable grounds. Failure to ~~pay--any--judgment--against--a self-insurer,~~ provide liability protection or personal injury protection benefits required by K.S.A. 40-3107 and 40-3109, and amendments thereto, or pay any liability imposed by law arising out of the ownership, operation, maintenance or use of a motor vehicle registered in such self-insurer's name, ~~within--30--days after--such--judgment--shall--have--become-final,~~ or to otherwise comply with the requirements of this subsection shall constitute reasonable grounds for the cancellation of a certificate of self-insurance. Reasonable grounds shall not exist unless such objectionable activity occurs with such frequency as to indicate a general business practice.

Self-insureds shall investigate claims in a reasonably prompt manner, handle such claims in a reasonable manner based on available information and effectuate prompt, fair and equitable settlement of claims in which liability has become reasonably clear.

As used in this subsection, "liability imposed by law" means the stated limits of liability as provided under subsection (e) of K.S.A. 40-3170, and amendments thereto.

Nothing in this subsection shall preclude a self-insurer from

pursuing all rights of subrogation against another person or persons.

(g) (1) Any person violating any provision of this section shall be guilty of a class B misdemeanor and shall be subject to a fine of not less than $200 nor more than $1,000 or confinement in the county jail for a term of not more than six months, or both such fine and confinement.

(2) Any person convicted of violating any provision of this section within three years of any such prior conviction shall be guilty of a class A misdemeanor.

(h) In addition to any other penalties provided by this act for failure to have or maintain financial security in effect, the director, upon receipt of a report required by K.S.A. 8-1607 or 8-1611, and amendments thereto, or a denial of such insurance by the insurance company listed on the form prescribed by the secretary of revenue pursuant to subsection (d) of this section, shall, upon notice and hearing as provided by K.S.A. 40-3118, and amendments thereto, suspend:

(1) The license of each driver in any manner involved in the accident;

(2) the license of the owner of each motor vehicle involved in such accident, unless the vehicle was stolen at the time of the accident, proof of which must be established by the owner of the motor vehicle. Theft by a member of the vehicle owner's immediate family under the age of 18 years shall not constitute a stolen vehicle for the purposes of this section;

(3) the registrations of all vehicles owned by the owner of each motor vehicle involved in such accident;

(4) if the driver is a nonresident, the privilege of operating a motor vehicle within this state; or

(5) if such owner is a nonresident, the privilege of such owner to operate or permit the operation within this state of any motor vehicle owned by such owner.

(i) The suspension requirements in subsection (h) shall not apply:

(1) To the driver or owner if the owner had in effect at the time of the accident an automobile liability policy as required by K.S.A. 40-3107, and amendments thereto, with respect to the vehicle involved in the accident;

(2) to the driver, if not the owner of the vehicle involved in the accident, if there was in effect at the time of the accident an automobile liability policy with respect to such driver's driving of vehicles not owned by such driver;

(3) to any self-insurer as defined by subsection (u) of K.S.A. 40-3103, and amendments thereto;

(4) to the driver or owner of any vehicle involved in the accident which was exempt from the provisions of this act pursuant to K.S.A. 40-3105, and amendments thereto;

(5) to the owner of a vehicle described in subsection (a)(2).

(j) For the purposes of provisions (1) and (2) of subsection (i) of this section, the director may require verification by an owner's or driver's insurance company or agent thereof that there was in effect at the time of the accident an automobile liability policy as required in this act.

Any suspension effected hereunder shall remain in effect until satisfactory proof of financial security has been filed with the director as required by subsection (d) of K.S.A. 40-3118, and amendments thereto, and such person has been released from liability or is a party to an action to determine liability pursuant to which the court temporarily stays such suspension pending final disposition of such action, has entered into an agreement for the payment of damages, or has been finally adjudicated not to be liable in respect to such accident and evidence of any such fact has been filed with the director and has paid the reinstatement fee herein prescribed. Such reinstatement fee shall be $25 except that if the registration of a motor vehicle of any owner is suspended within one year following a prior suspension of the registration of a motor vehicle of such owner under the provisions of this act such fee

shall be $75.

(k) The provisions of this section shall not apply to motor carriers of property or passengers regulated by the corporation commission of the state of Kansas.

(l) The provisions of subsection (d) shall not apply to vehicle dealers, as defined in K.S.A. 8-2401, and amendments thereto, for vehicles being offered for sale by such dealers.