Approved: 3-6-97
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 20, 1997 in Room 526-S of the Capitol.

All members were present except:

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

Conferees appearing before the committee:

Lawrence T. Buening, Jr., Executive Director, Kansas Board of Healing Arts
State Senate Janis Lee
Roberta Johnson, Associate General Counsel, Via Christi Health System, Wichita and Kansas Hospital Association
Terry Humphrey, Executive Director, Kansas Trial Lawyers Association
Anthony Kovac, M.D., Kansas Respiratory Care Society
Meg Henson, Director of Government Affairs, Kansas Medical Society
Tom Bell, Legal Counsel, Kansas Hospital Association

Others attending: See attached list

Approval of Minutes

Senator Becker made a motion to approve the Committee minutes of February 10, 11, 12, 13, 14, 1997, seconded by Senator Hardenburger. The motion carried.

Hearing on SB 244 - Fees paid to state board of healing arts

Larry Buening, Kansas Board of Healing Arts, testified before the Committee in support of **SB 244** which would raise the statutory fees collected by the Board of Healing Arts. Mr. Buening stated in his written testimony that the Board does not anticipate increasing fees to the proposed statutory maximums any time in the foreseeable future. The proposed increases should be adequate to carry the Board well into the 21st century and to meet any additional expectations and demands placed upon it by this legislature and other entities. (Attachment 1)

There were no opponents to **SB 244**.

Action on SB 244

After Committee discussion on **SB 244**, Senator Langworthy made a motion the Committee recommend **SB 244** favorably for passage, seconded by Senator Jones. The motion carried.

Hearing on SB 245 - Hospital liens upon personal injury damages recovered by patients

State Senator Janis Lee expressed her support for **SB 245** which would amend the lien law concerning hospitals in Kansas. Senator Lee called the Committee's attention to testimony that was given by R. L. Heath representing Via Christi Health System regarding 1996 **SB 277** as well as a balloon of **SB 245** showing proposed changes agreed to by the Kansas Hospital Association and the Kansas Trial Lawyers Association. The lien law concerning hospitals in Kansas has been amended by this bill to do the following: (1) Hospitals will be allowed to assert a lien unlimited in amount, (2) Liens of $5,000.00 or less and the first $5,000.00 of liens greater than $5,000.00 shall be fully enforceable as they are under present law, and (3) Lien sums above $5,000.00 shall only be enforceable to the extent their enforcement constitutes an equitable distribution of the recovery under the circumstances. If a hospital and an injured victim cannot agree on what constitutes an equitable distribution under the circumstances, the matter is submitted to a court for determination. This procedure allows the court to fashion an equitable distribution of the recovery based upon all prevailing factors including the amount of the hospital lien, the nature and extent of the victim's actual damages and the amount of the recovery. (See Attachment 2)

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE, Room 526-S Statehouse, at 10:00 a.m. on February 20, 1997.

Roberta Johnson, Associate General Counsel in the legal office of Via Christi Health System, Wichita, and a representative of the Kansas Hospital Association, and Terry Humphrey, Executive Director, Kansas Trial Lawyers Association, both expressed their support for **SB 245** with the proposed amendments agreed upon as shown in their written testimony. (Attachments 3 and 4)

There were no opponents to **SB 245**.

Action on SB 245.

Senator Lee made a motion the Committee adopt the proposed amendments agreed to by KHA and KTLA on **SB 245**, and that the Committee recommend **SB 245 as amended** favorably for passage, seconded by Senator Hardenburger. The motion carried.

Hearing on SB 242 - Respiratory therapist licensure

Anthony L. Kovac, M.D., representing the Kansas Respiratory Care Society, expressed his support for **SB 242**, which would require the licensing of respiratory therapists by the Kansas Board of Healing Arts. Current law requires people in this profession to be registered by the Board, but not licensed. The bill provides that the Board may waive the examination and education requirements and issue a license to individuals who have not taken and passed a licensure examination administered by the Board under certain conditions. (Attachment 5)

Meg Henson, Kansas Medical Society, expressed her support for **SB 242** as noted in her written testimony (Attachment 6) and also offered two technical amendments that would be consistent with language in the statute -- on page 8, line 23 (5), "Persons licensed to practice medicine and surgery" and striking "Medical practitioners" and on page 9, line 15 (e) to insert the word "and surgery" after the word "medicine".

Tom Bell, Kansas Hospital Association, testified in support of **SB 242**. Mr. Bell noted that most of the concerns he had relating to functions of other health care providers had been addressed in the bill. (Attachment 7)

Larry Buening, Kansas Board of Healing Arts, testified in opposition to **SB 242** because (1) the State Board of Healing Arts has only licensed individuals who qualify to use the term "Doctor" in the health care setting, (2) all currently registered individuals under the jurisdiction of the Board can receive temporary permits without having met all the requirements for permanent registration by passing the required examinations, and (3) there is a concern on behalf of the Board that licensing respiratory therapists would create a confusion on behalf of the citizens of the state as to the scope of practice of this profession. (Attachment 8)

Written testimony with comments on the bill was submitted by Lesa Bray, Kansas Department of Health and Environment (Attachment 9), and Patsy Johnson, Kansas State Board of Nursing (Attachment 10).

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for February 21, 1997.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-20-97

NAME	REPRESENTING
Mary Ellen Conlee	Via Christi Health Sys
Rolalita R. Johnson	Via Christi Health System
Lisa Bray	KDHE/HOC
Pat Johnson	Bd of Nursing
Venesa Sottenauer	State Farm
Loretta Hoerman	KAPA
Doug Smith	KAPA
Amy Campbell	R. Rice Law Office
Susan M. Baker	Hein + Weir
Karen S. Schell	Kansas Respiratory Care Society
Suzanne Bollig	KS Respiratory Care Society
Dawn Reid	KSNA
Anthony L. Kovac MD	Kansas Respiratory Care Society
Kevin LaChance	KS Bd of Healing Arts
Larry Buening	KS Bd of Healing Arts
Bob McDaniel	KS Bd of EMS

KANSAS BOARD OF HEALING ARTS

BILL GRAVES
Governor

LAWRENCE T. BUENING, JR.
Executive Director

235 S. Topeka Blvd.
Topeka, KS 66603-3068
(913) 296-7413
FAX # (913) 296-0852

MEMORANDUM

TO: Senate Committee on Public Health and Welfare

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 19, 1997

RE: **SENATE BILL NO. 244**

Senator Praeger and members of the Committee, thank you for the opportunity to appear on behalf of the State Board of Healing Arts in support of Senate Bill No. 244. This bill was requested for introduction by the Board. Quite simply, it is the Board's desire that of all the bills which mention the State Board of Healing Arts or affect its operations in some regard, we hope you would give this bill your greatest attention and consideration of passage.

The Board currently licenses, registers or certifies approximately 14,000 individuals in 11 health care professions. Of these professions, the three branches of the healing arts as defined when the Board was created in 1957 - medicine and surgery, osteopathic medicine and surgery and chiropractic - comprise almost 9,000 of the individuals regulated by the Board. Because of these numbers and the licensure credentialing, these three professions under the Healing Arts Act provide the majority of the funding for the Board. Therefore, in an attempt to

MEMBERS OF BOARD
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ROBERT L. FRAYSER, D.O., HOISINGTON
LANCE MALMSTROM, D.C., TOPEKA
LAUREL H. RICKARD, MEDICINE LODGE
CHRISTOPHER P. RODGERS, M.D., HUTCHINSON
HAROLD J. SAUDER, D.P.M., INDEPENDENCE
EMILY TAYLOR, LAWRENCE

Senate Public Health & Welfare
Date: 2-20-97
Attachment No. 1

reduce the paperwork and figures required for you to assimilate, the attachments to this testimony have been limited to the healing arts licensees although I have similar information also for the other professions regulated by the Board. Although I have brought a substantial amount of information with me, I am sure a question will arise for which I will not have the answer readily at hand. For that, I apologize in advance and will assure each of you that if there are any questions I cannot answer this morning, I will try to have the answer to you by this afternoon.

Included as ATTACHMENT 1 is a listing of the fees charged by the various medical boards throughout the country for both initial license by endorsement and for re-registration or renewal. According to column 2 of ATTACHMENT 1, the initial licensure fee of $150 currently charged by the Board pursuant to its statutory maximum is substantially less than a majority of the medical boards throughout the United States. While the re-registration or renewal fee at the statutory maximum of $150 is in the upper half of the fees charged on an annual basis, other factors must also be considered. The State Board of Healing Arts has its own staff attorneys for both prosecuting disciplinary cases and providing advice to the Board. Salaries for the attorneys are paid from the Healing Arts fee fund with no state general revenue being expended. It also has its own investigators and provides substantially all of the funding for six Impaired Provider Programs operated under contract with the Board. Comparisons of each of the medical boards and the fees charged must also take into consideration the services provided. In Nebraska, the medical board is part of the umbrella Nebraska Health Department which has 25 investigators to investigate matters involving 26 health professions including nursing homes. Disciplinary cases are referred to the Attorney General for prosecution. In most states, funding for services by the Attorney General are funded by general revenue dollars. A $2 surcharge is assessed against each license for the operation of Impaired Provider Programs. In Oklahoma, respiratory therapists are charged $75 for an application, physical therapists and physical therapist assistants are charged $125 for applications and $75 and $50 respectively for renewals. In Missouri, all disciplinary cases are handled by the Attorney General rather than staff attorneys. The application fee for a physical therapist is $215 and $125 for a physician's assistant. Such anomalies exist throughout all of the medical boards making true comparisons of costs difficult.

ATTACHMENT 2 gives a brief overview of the fees charged under the Healing Arts Act to the three professions to which it specifically and originally pertained. This provides both the statutory maximum and current fees charged by the Board. In addition, it provides the number of different categories of licenses

issued in FY95, FY96 and FY97 (estimated) as well as the revenue generated from each category for each year.

ATTACHMENT 3 is a synopsis of each of the fees and provides both the dates each of the statutory maximums were last increased and the history of the fees which have been collected by the Board under rule and regulation.

The primary purpose the Board has requested the Legislature to act on Senate Bill No. 244 is the decreasing balances in the Board's fee fund. This is illustrated below by the beginning fee fund balances from July 1, 1992 through July 1, 1999 based upon current fees charged by the Board, which in large part, are already at the statutory maximum:

July 1, 1992	**$1,154,512**
July 1, 1993	**$1,049,316**
July 1, 1994	**$1,131,192**
July 1, 1995	**$1,064,371**
July 1, 1996	**$ 911,075**
July 1, 1997	**$ 804,522***
July 1, 1998	**$ 731,477***
July 1, 1999	**$ 716,943***

*Based upon The Division of The Budget and Governor recommendations.

Expenditure limitations for the fiscal years involved have been or are recommended to be as follows:

FY93	**$1,267,013**
FY94	**$1,333,617**
FY95	**$1,467,608**
FY96	**$1,606,943**
FY97	**$1,577,418**
FY98	**$1,624,474***
FY99	**$1,690,309***

*Based upon The Division of the Budget and Governor recommendations.

Actual receipts for FY96 amounted to $1,678,747 less $200,000 to the state general fund. Projected receipts for FY97, FY98 and FY99 are $1,695,865, 1,786,800 and 1,868,745, respectively, less $200,000 each year to the state general fund.

While the shortfall for each year is not excessive, two factors must be considered. The first factor is that more than 50% of the Board's total receipts are received in June of each year. Therefore, beginning fee fund balances must be adequate to enable the Board to operate for 11 of the first 12 months of each fiscal year. Currently, the licenses of MDs, DOs, DCs and DPMs all expire on June 30 of each year. Therefore, the renewal fees for each of these four professions are received primarily in June of each year. In June 1995, the Board had receipts totaling $930,642 while in June 1996 receipts amounted to $989,023. Expenses, however, are fairly consistent throughout the year. The Board fee fund will have an extremely low balance by May 1997 and, without an increase in fees, the Board will not have adequate reserves for FY98.

The second factor involved is that the Board is being expected to do more. Full-time employee positions for FY97 have not been increased over FY96. Similarly, the recommendations for both FY98 and FY99 do not reflect an increase in Board personnel. However, several factors are operating which may result in an increase in Board responsibilities and duties in the future. Bills have been introduced in this and in previous legislative sessions to add to the number of professions the Board regulates. Secondly, many persons and entities are seeking additional information and statistics from the Board - information that is not now being collected, entered into a database, nor disseminated to the public. While there is a need for this information, particularly by the Legislature in making major policy decisions and by the public in making decisions regarding health care providers, resources and funding have not been appropriated to enable the Board to accomplish these aims.

In conclusion, the Board strongly requests your favorable consideration of Senate Bill No. 244. The Board does not anticipate increasing fees to the proposed statutory maximums any time in the foreseeable future. The proposed increases, however, should be adequate to carry the Board well into the 21st century and to meet any additional expectations and demands placed upon it by this Legislature or other entities. The actual increase in fees charged must be set by rule and regulation and will not be collected until FY98 and, prior to that time,

will undergo the scrutiny of public hearing and the Joint Committee on Rules and Regulations.

Thank you again for your attention and willingness to consider this bill. I would be happy to answer any questions either now or at any other time.

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Table 20
Fees for Issuing Medical Licenses by Examination and by Endorsement and License Reregistration Intervals and Fees; CME Requirements

State	Examination USMLE Step 3[1]	Endorsement	Licensure Reregistration: Registration Interval (Years)	Fee	CME Required
Alabama	$350[2]	175[3]	1	100	X
Alaska	400[4]	440	2	440	X
Arizona	550	450[5]	1	200[6]	X
Arkansas	400	400	1	10	
California	400	814	2	575	X
Colorado	400	329	2	214	
Connecticut	400[4]	450	1	450	
Delaware	350[4]	160[2]	2	163	X
DC	590	300	2	120	
Florida	1,010	460	2	355	X
Georgia	135	300	2	105	X
Guam	See 7	150	2	60	X
Hawaii	See 8	290	2	240	X
Idaho	245	300	1	125	
Illinois	400	300	3	300[9]	X
Indiana	125[4]	200	2	50	
Iowa	450[4]	300	2	150	X
Kansas	450	150	1	150	X
Kentucky	415	250	1	100	X
Louisiana	465	200	1	100	
Maine	400	350	2	200	X
Maryland	500	400[2]	2	400[2]	X
Massachusetts	450	350	2	250	X
Michigan	500[4]	140	3	270	X
Minnesota	400	200	1	168	X
Mississippi	500[4]	500	1	100	
Missouri	450	450	1	120	X
Montana	500	250	1	150[10]	
Nebraska	300[4]	201	2	102	
Nevada	See 4	250	2	420[10]	X
New Hampshire	See 11	250	1	100	X
New Jersey	400	225[2]	2	340	
New Mexico	350[4]	350	3	210	X
New York	420	465	2	330	
North Carolina	700	250	2	200	
North Dakota	415	200	1	110	
Ohio	325[2]	325	2	250	X
Oklahoma	300	400	1	150	
Oregon	See 4	270	2	330[10,12]	
Pennsylvania	370[13]	20[14]	2	80	
Puerto Rico	500	200	3	75	X
Rhode Island	See 8	350	1	200	X
South Carolina	600	500	1	80	
South Dakota	550	200	1	50	
Tennessee	See 4	235	2	110	
Texas	800	800	1	300	X
Utah	530[4]	130	2	100	
Vermont	See 7	190	2	205	
Virgin Islands	See 7		1	200	X
Virginia	See 4	300	2	125	
Washington	See 4	300[15]	1	225	X
West Virginia	600	200	2	200[10]	X
Wisconsin	468	73	2	102	X
Wyoming	360[4]	250	1	100	

X indicates yes. [1]Step 3 fees include exam costs and exam processing fees. [2]Plus $175 application fee (AL); plus $25 application fee (DE); plus $50 fee to fund Physician Rehabilitation Program (MD); plus $325 nonrefundable application fee (NJ); plus administrative costs (OH). [3]Oral exam is $400. [4]Federation of State Medical Boards administers examination. [5]If less than 10 years since passing a written examination for licensure in another state, $550 for endorsement requiring SPEX exam. [6]A late penalty fee of $350 is charged if renewal is not submitted by February 1 of each year. License automatically expires May 1 if renewal and late penalty fee are not submitted. [7]No information provided. [8]Does not process or administer exam. [9]Nonresidents $600. Penalty fee of $100 is charged if renewal is not submitted by July 31 in the year of renewal. [10]$150 active; $60 inactive (MT); $150 inactive (NV); $270 biennial inactive or out-of-state (OR): $100 inactive (WV). [11]Undetermined at this time. [12]Biennial. [13]Subject to change in 1996. [14]US/Canadian is $20; IMG is $80. [15]Plus $25 if initial applicant.

1-6

ATTACHMENT 1

HEALING ARTS ACT

DESCRIPTION	STATUTORY MAXIMUM & CITE	CURRENT FEES & CITE	FY 95 NUMBERS	FY 95 FEES	FY 96 NUMBERS	FY 96 FEES	ESTIMATED FY 97 NUMBERS
(A) LICENSE (Examination)	$ 150	$150	648	$ 97,200	746	$ 111,900	850 - $ 127,500
(B) LICENSE (Endorsement)	$ 150	$150					
(C) LICENSE (National Boards)	$ 150	$150					
(D) ANNUAL RENEWAL	$ 150	$150	6,978	$1,046,700	7,216	$1,082,400	7,500 - $1,125,000
(E) TEMPORARY PERMIT	$ 30	$ 30	466	$ 13,980	490	$ 14,700	515 - $ 15,450
(F) INSTITUTIONAL LICENSE	$ 150	$150	10	$ 1,500	4	$ 600	5 - $ 750
(G) VISITING PROFESSOR LICENSE	$ 25	$ 25	1	$ 25	1	$ 25	2 - $ 50
(H) CERTIFIED STMT OF LICENSE	$ 15	$ 15	47	$ 705	36	$ 540	40 - $ 600
(I) COPY OF LICENSE	$ 15	$ 15	31	$ 465	29	$ 435	35 - $ 525
(J) EXAMINATION	Cost	$450	97	$ 43,650	138	$ 62,100	
(K) SPECIAL PERMIT	$ 30	$ 30	7	$ 210	4	$ 120	5 - $ 150
(L) EXEMPT OR INACTIVE (New or Renewal)	$ 150	(New/Inact.Renewal) $150 (Exempt & Renewal) $115	718	$ 82,570	771	$ 88,665	825 - $ 94,875
(M) CONVERSION OF EXEMPT OR INACTIVE	$ 150	$ 35	76	$ 2,660	42	$ 1,470	40 - $ 1,400
(N) REINSTMT OF REVOKED LIC	$ 1,000	$1,000					
(O) VISITING CLINICAL PROF LICENSE (New or Renewal)	$ 150	(New) $150 (Renewal) $115					
(P) POSTGRADUATE PERMIT	$ 30	$ 30	230	$ 6,900	245	$ 7,350	260 - $ 7,800

ATTACHMENT 2

HEALING ARTS ACT

DESCRIPTION	STATUTORY MAXIMUM & CITE	CURRENT FEES & CITE	FY 95 NUMBERS	FY 95 -FEES	FY 96 NUMBERS	FY 96 FEES	ESTIMATED FY 97 NUMBERS
(Q) LIMITED PERMIT (New or Renewal)	$ 30						
(R) LATE RENEWAL OF LICENSE	$ 500 65-2809	$ 50	349	$ 17,450	402	$ 20,100	450 - $ 22,500
(S) REINSTATEMENT	$ 500 65-2809	$250	110	$ 27,500	117	$ 29,250	125 - $ 31,250
(T) TEMPORARY EDUCATION LIC	$ 25 65-28,123	$ 25 65-28,123(e)	3	$ 75	4	$ 100	5 - $ 125
TOTALS				$ 1,341,590		$ 1,419,755	$ 1,428,975

8-1

PODIATRY

(K.S.A. 65-2012)

DESCRIPTION	STATUTORY MAXIMUM & CITE	CURRENT FEES & CITE	FY 95 NUMBERS	FY 95 FEES	FY 96 NUMBERS	FY 96 FEES	ESTIMATED FY 97 NUMBERS
(A) LICENSE (Examination)	$150 KSA 65-2012	$150					
(B) LICENSE (Endorsement)	$150 "	$150	6	$ 900	5	$ 750	7 - $1,050
(C) LICENSE (From Exempt)	$150 "						
(D) EXEMPT LICENSE (New/Renewal)	$150 "	$150 (New) $115 (Renewal)	5	$ 575			5 - $ 575
(E) ANNUAL RENEWAL	$150 "	$150	101	$ 15,150	96	$14,400	99 - $14,850
(F) ADDITIONAL LATE RENEWAL	$100 " KSA 65-2005(b)	$ 50	7	$ 350	5	$ 250	5 - $ 250
(G) ADDITIONAL REINSTATEMENT	$100 KSA 65-2012	$100	2	$ 200			1 - $ 100
(H) TEMPORARY PERMIT	$ 30 "	$ 30	6	$ 180	4	$ 120	6 - $ 180
(I) TEMPORARY LICENSE	$ 25 "	$ 25					
(J) EXAMINATION	Cost + Administration "	$400	3	$ 1,200	6	$ 2,400	9 - $ 3,600
(K) CERTIFIED STMT OF LICENSE	$ 15 "	$ 15	1	$ 15	1	$ 15	1 - $ 15
(L) COPY OF LICENSE	$ 15 "	$ 15					

TOTALS: .... $18,570 $17,935 $ 20,620

FEES TO BE CHARGED TO PRACTITIONERS OF THE HEALING ARTS

(a) For a license, issued upon the basis of an examination given by the board, authorized fee of not more than $150. K.S.A. 1996 Supp. 65-2852 *(no change since 1985)*;

K.A.R. 100-11-1(a) actual fee

1983, $130;

1986, $150.

(b) for a license, issued without examination and by endorsement, authorized fee of not more than $150. K.S.A. 1996 Supp. 65-2852 *(no change since 1985)*;

K.A.R. 100-11-1(b)

1983, $130;

1986, $150.

(c) for a license, issued upon a certificate from the national boards, authorized fee of not more than $150. K.S.A. 1996 Supp. 65-2852 *(no change since 1985)*;

K.A.R. 100-11-1(c)

1983, $130;

1986, $150.

(d) for the annual renewal of a license, authorized fee of not more than $150. K.S.A. 1996 Supp. 65-2852 *(increased from $100 in 1987)*;

K.A.R. 100-11-1(e)

1983, $50;

1986, $75;

1987, $100;

1990, $150.

(e) for a temporary permit, authorized fee of not more than $30. K.S.A. 1996 Supp. 65-2852 *(no change since 1985)*;

K.A.R. 100-11-1(f)

1983, $30;

(f) for an institutional license, authorized fee of not more than $150. K.S.A. 1996 Supp. 65-2852 *(added in 1985)*;

K.A.R. 100-11-1(g)

1986, $150.

(g) for a visiting professor temporary license, authorized fee of not more than $25. K.S.A. 1996 Supp. 65-2852 *(no change since 1985)*;

K.A.R. 100-11-1(h)

1983, $15;

1994, $25.

ATTACHMENT 3

(h) for a certified statement from the board that a licensee is licensed in this state, authorized fee of not more than $15. K.S.A. 1996 Supp. 65-2852 *(no change since 1985)*;

K.A.R. 100-11-1(i)

1983, $15.

(i) for any copy of any license issued by the board, authorized fee of not more than $15. K.S.A. 1996 Supp. 65-2852 *(no change since 1985)*;

K.A.R. 100-11-1(j)

1983, $15.

(j) for any examination given by the board, a sum in an amount equal to the cost to the board of the examination. K.S.A. 1996 Supp. 65-2852 *(no change since 1985)*;

(k) for application for and issuance of a special permit under K.S.A. 65-2811a and amendments thereto, authorized fee of not more than $30. K.S.A. 1996 Supp. 65-2852 *(increased from $15)*;

K.A.R. 100-11-1(l)

1983, $15;

1994, $30.

(l) for an exempt or inactive license or renewal of an exempt or inactive license, authorized fee of not more than $150. K.S.A. 1996 Supp. 65-2852 *(added in 1987)*;

K.A.R. 100-11-1(a)

Initial: $150;

K.A.R. 100-11-1(n)

Renewal:1990, $115.

(m) for conversion of an exempt or inactive license to a license to practice the healing arts, authorized fee of not more than $150. K.S.A. 1996 Supp. 65-2852 *(added in 1987)*;

K.A.R. 100-11-1(o)

1993, $35

(n) for reinstatement of a revoked license, authorized fee of not more than $1,000*(added in 1981)*;

K.A.R. 100-11-1(q)

1993; $1000

(o) for a visiting clinical professor license, or renewal of a visiting clinical professor license, authorized fee of not more than $150. K.S.A. 1996 Supp. 65-2852 *(added in 1982)*;

K.A.R. 100-11-1(r)

1993; $150

(p) for a postgraduate permit, authorized fee of not more than $30. K.S.A. 1996 Supp. 65-2852 *(added in1995)*;

K.A.R. 100-11-1(m)

1983; $25

1994; $30

(q) for a limited permit or renewal of a limited permit, authorized fee of not more than $30. K.S.A. 1996 Supp. 65-2852 *(added in 1995).*

[For federally active license]

(r) late renewal of license authorized fee of not more than $500. K.S.A. 1996 Supp. 65-2809 *(increased from $50 in 1986).*

[For Late renewal or second notice, prior to cancellation]

K.A.R. 100-11-1(e)(2)

1983; $75

1986; $100

1990; $50

(s) reinstatement of cancelled license, authorized fee of not more than $500. K.S.A. 1996 Supp. 65-2809 *(increased from $50 in 1986).*

[Reinstatement renewal, following cancellation]

K.A.R. 100-11-1(e)(3)

1983; $75

1986; $150

1990; $250

(t) tepmorary education license in a sum of $25. K.S.A. 65-28,123 *(added in 1989).*

K.A.R. 100-11-1(f)

This is a copy of part of the testimony that was given by R.L. Heath representing Via Christi Health System regarding SB277 which was before the 1996 Legislature.

It may be helpful to give you a short legislative history of the lien law in the State of Kansas. In 1939, the Kansas legislature first enacted a law permitting a hospital to have a lien for the reasonable and necessary charges for hospital care arising from all causes of action for damages occurring to a patient. The original bill provided a lien in an amount not to exceed $200, presumably the reasonable and necessary charges for hospital services in 1939.

Twelve years later, in 1951, the legislature more than tripled the amount of the lien to $700 recognizing rising healthcare costs and inflation. Six years later, in 1957, the legislature saw fit to increase the amount once again by more than doubling the lien amount to $1,500.

Fifteen years then passed, and in 1972 the lien amount was once again modified to the current sum of $5,000. For the last 24 years, the lien amount has remained constant at $5,000, while healthcare costs and inflation has driven the cost of healthcare to unprecedented levels. By today's standards, the $5,000 limit is totally inadequate to cover the reasonable and necessary charges of a hospital admission.

<u>Lien Laws of Other Jurisdictions</u>

The State of Oklahoma permits hospitals to have "a lien upon that part going or belonging to such patient of any recovery or sum had or collected or to be collected by such patients, or by his heirs, personal representatives or next of kin in the case of death, whether by judgment or settlement or compromise to the amount of the reasonable and necessary charges of such hospital for the treatment, care and maintenance of such patient . . ." O.S. 42 Section 43.

The State of Colorado in its lien law found that C.R.S. 38-27-101 provides that every hospital duly licensed by the Department of Public Health and Environment which furnishes services to any person injured as the result of negligence or the wrongful act of another . . . shall have a lien for all reasonable and necessary charges for hospital care upon the net amount payable to such injured person, his heirs and assigns or legal representative out of the total amount of any recovery or sum had or collected . . . on account of such injuries.

The State of Nebraska in Article 4, Section 52-401 provides that when any person employs a physician, nurse or hospital to perform professional services of any nature in connection with the treatment of an injury and thereafter claims damages from the party causing the injury, such physician, nurse or hospital shall have a lien upon any sum awarded the injured person in judgment or obtained by way of settlement or compromise for the usual and customary charges of such physician, nurse or hospital applicable at the time the services are performed.

The State of Texas permits a hospital lien "for the amount of charges of such hospital for such treatment, care and maintenance as may be given to the injured person." Article 5506A, Section 1.

The State of New Mexico permits a lien to the extent of the reasonable and usual and necessary hospital charges for treatment, care and maintenance of the injured party in the hospital to the date of payment. New Mexico Statutes 48-8-1.

The State of Arkansas also permits hospitals to have a lien for the value of services rendered or to be rendered. See Medical Nursing and Hospital Lien Act, 18-46-104.

The same general provisions are applicable for customary charges in the states of Arizona, Delaware and New York.

We have a number of instances that clearly demonstrates the inappropriateness of the current law and how it has worked to the detriment of the community hospital resulting in substantial financial losses because of the limitation on the lien. Most cases involve patients who receive treatment and care in the hospital and either by design or otherwise, delay payment of the hospital bill. The patient then settles with the insurance company for a large amount, pays to the hospital the statutory lien amount of $5,000 (which in most cases is only a fraction of the bill) and the remaining settlement proceeds then split between the patient and the patient's lawyer.

In some cases, the hospital is forced to file a lawsuit against the patient for collection of the account only to discover that the patient has already received a substantial sum of money in settlement and has utilized the settlement proceeds to pay for a house, care or other exempt property.

What follows is a few actual case examples of how the hospital suffers financial losses as a result of the lien limitation at $5,000.

Actual Cases

Case No. 1: Patient was admitted to hospital for injuries resulting from an automobile accident. Medical charges of $73,671.84 were incurred. Upon discharge, the patient's attorney contacted the hospital assuring settlement would be forthcoming. Hospital then received a direct payment for $5,000. One month later, the hospital was advised that the patient had settled with his insurance company, had purchased a new pickup truck and a new mobile home and would be filing bankruptcy. The attorney for the patient indicated that settlement had occurred and that they were only legally obligated to pay St. Joseph Medical Center $5,000. The hospital sustained a loss in excess of $69,000. The insurance settlement was for $100,000.

Case No. 2: Patient admitted to hospital with head injury from Bartlesville, Oklahoma. Patient had been previously treated at KU Med Center for 6 weeks then transferred to St. Joseph Medical Center in Wichita. Patient incurred a medical bill of $81,631.57. Insurance adjuster indicated an offer of $100,000 had been made which had been declined by the patient. The attorney for the patient agreed to pay $5,000 statutory lien only. Thereafter, it was discovered the hospital in Bartlesville, Oklahoma had filed a hospital lien under the law of the State of Oklahoma in the amount of $60,000 (in Oklahoma there is no cap on hospital liens) and ultimately recovered the amount of its lien. Under this scenario, the Kansas law worked to the detriment of the Kansas hospital which was allowed to recover only $5,000 for its lien, while the Oklahoma hospital was able to collect its entire hospital bill in excess of $60,000.

It should be noted that this patient was ultimately determined to be eligible for Medicaid. Medicaid paid the hospital $51,919. This action, while benefiting the hospital (which still took a loss of $25,000) caused a drain on the Kansas Medicaid program and the citizens of Kansas when liability insurance proceeds should have covered the entire amount of the bill.

Case No. 3: Patient admitted to the Medical Center after automobile accident incurring $21,987 bill. Sensing a settlement was in the making, the hospital filed suit and obtained a temporary restraining order against the insurance company. The patient obtained $100,000 settlement from the insurance company. $5,000 was sent directly to the hospital. The attorney for the patient contacted the hospital and stated if the hospital did not accept $10,000 in full settlement, the client/patient would be filing bankruptcy after his portion of the funds were put into exempt assets. The hospital ultimately wrote off $6,000 plus interest of its charges.

Case No. 4: Patient admitted to Medical Center for 107 days. A hospital bill of $106,385.80 was incurred. The patient's attorney allegedly advised the patient not to give his Medicaid card to the hospital since ultimately Medicaid would be able to recover any proceeds paid. While negotiations were ongoing with the attorney, a payment of $5,000 was sent direct to the hospital. Insurance settlement then followed in the amount of $126,177 of which the attorney recovered $43,725.77 with a net recovery to the patient of $82,451.54. Two months later, the patient filed bankruptcy. Proceeds of the settlement had been channeled into exempt assets. However, the Bankruptcy Trustee discovered some debt preferences and by virtue of pursuing the matter aggressively, the hospital was able to recover approximately $15,000 from the bankruptcy proceeding. However, ultimately it lost $86,000 on the hospital admission.

Conclusion

Clearly, as these cases demonstrate, if the hospital lien law is to serve its purpose, the hospital must be able to enjoy a lien to the extent of reasonable and necessary charges. All too often, the hospital's collection efforts are stymied or frustrated by the limited lien amount which is totally unrealistic in the healthcare world of 1997. The unfortunate result is that patients receive "double recovery" in the form of "free" medical care which is never paid for in addition to a sizable monetary settlement from the insurance company that includes medical costs and expenses as an item of damage that is recoverable by the patient.

Sen. Jannsen/ee

LAW OFFICES OF
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December 15, 1995

Tom Bell 233-7436
General Counsel
Kansas Hospital Association
P. O. Box 2308
215 E. 8th Street
Topeka, KS 66601

Re: Suggested amendments to K.S.A. 65-406

Dear Tom:

As mentioned during our telephone conversation today, I believe that K.S.A. 65-406 should be amended to more accurately deal with medical expenses incurred for emergency services in the modern era.

I was recently retained to represent the interest of Good Samaritan Hospital, located in Kearney, Nebraska, relative to a hospital bill incurred in providing emergency services for a Kansas resident who was injured in an automobile accident in Phillips County, Kansas. The medical expenses were more than $25,000.00. When I was retained to represent the interest of the hospital, a law suit had already been commenced by the injured party in the District Court of Phillips County, Kansas. Under the provisions of the existing statute, Good Samaritan Hospital was not entitled to claim a lien under the referenced statute because the statute applies only to hospitals "in the state of Kansas". Nonetheless, I contacted the plaintiff's attorney and suggested a voluntary lien. My inquiry was ignored. I then filed suit against the party for whom the medical services were provided, who is also the plaintiff in the then pending lawsuit, and while attempting to obtain service of process upon the former patient, through her attorney, she negotiated a secret settlement (she recovered $50,000.00). Her attorney retained a substantial portion of the recovery for attorney's fees and the remaining balance of approximately $30,000.00 was then used to buy a new vehicle and to make numerous other personal expenditures and otherwise dispose of the funds. When we finally learned of the secret settlement, approximately six months after the fact, there were no funds left, and the hospital bill remains unpaid. I might add that we were finally able to obtain service of process on the former patient within the last couple of weeks.

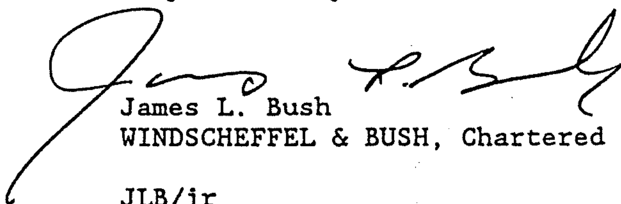
In light of the fact that all consumers bear the cost of hospital and medical expenses unpaid by others, it seems manifestly unjust to allow a party to file suit for recovery of medical expenses while, at the same time, impose upon such party no obligation to use the funds recovered for the actual payment of such expenses. To allow these types of occurrences is tantamount to

permitting a fraud upon the court. I would suggest, therefore, that the Kansas Hospital Association vigorously lobby for an amendment to K.S.A. 65-406 which would include an increase in the lien amount to a realistic level, permit and recognize the plaintiff's attorneys fees as an appropriate setoff against the lien, and to extend the statute to cover all hospitals, and not just those located in the state of Kansas. The $5,000.00 lien limit under the current statute, last amended in 1977, is not realistic in light of the costs of modern health care.

As mentioned during my telephone conversation with you, I would be very happy to testify in Topeka in support of suitable amendments to this statute.

By copy of this letter to Senator Janis Lee, with whom I have an excellent relationship, I am advising her of my position on this matter and of my concerns.

Very sincerely,



James L. Bush
WINDSCHEFFEL & BUSH, Chartered

JLB/jr

cc Senator Janis Lee

SENATE BILL No. 245

By Committee on Public Health and Welfare

2-10

AN ACT concerning hospital liens; amending K.S.A. 65-406 and repealing the existing section.

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

Section 1. K.S.A. 65-406 is hereby amended to read as follows: 65-406. *(a)* Every hospital ~~in the state of Kansas~~, which ~~shall furnish~~ *furnishes* emergency, medical or other service to any patient injured by reason of an accident not covered by the ~~workmen's~~ *workers* compensation act, ~~shall,~~ if such injured party ~~shall assert or maintain~~ *asserts or maintains* a claim against another for damages on account of such injuries, *shall* have a lien ~~not to exceed five thousand dollars ($5,000)~~ upon that part going or belonging to such patient of any recovery or sum had or collected or to be collected by such patient, or by ~~his~~ *such patient's* heirs, personal representatives or next of kin in the case of ~~his~~ *such patient's* death, whether by judgment or by settlement or compromise.

(b) Such lien shall be to the amount of the reasonable and necessary charges of such hospital for the treatment, care and maintenance of such patient in such hospital up to the date of payment of such damages~~:~~ ~~*Provided, however,* That this~~. *Such* lien shall not in any way prejudice or interfere with any lien or contract which may be made by such patient or ~~his~~ *such patient's* heirs or personal representatives with any attorney or attorneys for handling the claim on behalf of such patient [~~his~~] heirs or personal representatives~~:~~ ~~*Provided further,* That the~~. *Such* lien ~~herein set forth~~ shall not be applied or considered valid against anyone coming under the ~~workmen's~~ *workers* compensation act in this state.

or such patient's

[*(c) Such lien attaches only to the recovery allowed or awarded for such hospital services for which the lien is claimed.*

(d) In the event the amount of the lien or liens as defined by subsection (a), and other general and special damages claimed by the injured person, is larger than the actual amount of settlement or judgment in the personal injury action, and the parties cannot agree on the distribution, the funds generated by the judgment or settlement shall be submitted to the appropriate court for a determination of equitable pro rata distribution to parties claiming an interest in the funds. In no event shall the pro rata eq- [illegible]]

1 *of damages established pursuant to K.S.A. 60-249a and amendments*
2 *thereto or K.S.A. 60-1903 and amendments thereto. Any hospital with a*
3 *properly filed lien shall be given reasonable notice of any hearing to ap-*
4 *prove a proposed settlement between the injured party and the tortfeasor*
5 *and shall be entitled to appear and be heard on any proposed allocation*
6 *of damages at such hearing.*
7 Sec. 2. K.S.A. 65-406 is hereby repealed.
8 Sec. 3. This act shall take effect and be in force from and after its
9 publication in the statute book.

(c) In the event the claimed lien is for the sum of $5000 or less it shall be fully enforceable as contemplated by subsection (a) of this statute. In the event the claimed lien is for a sum in excess of $5,000 the first $5,000 of the claimed lien shall be fully enforceable as contemplated by subsection (a) of this statute, and that part of the claimed lien in excess of $5,000 shall only be enforceable to the extent that its enforcement constitutes an equitable distribution of any settlement or judgment under the circumstances. In the event the patient or such patient's heirs or personal representatives and the hospital or hospitals cannot stipulate to an equitable distribution of a proposed or actual settlement or a judgment, the matter shall be submitted to the court in which the claim is pending, or if no action is pending then to any court having jurisdiction and venue of the injury or death claim, for determination of an equitable distribution of the proposed or actual settlement or judgment under the circumstances.

TESTIMONY BEFORE SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

Senate Bill No. 245
February 20, 1997
Topeka, Kansas

Chairman Praeger, distinguished members of the Committee. My name is Roberta Johnson. I am an Associate General Counsel in the legal office of Via Christi Health System, which includes Via Christi Regional Medical Center and Our Lady of Lourdes Rehabilitation Hospital, both in Wichita, Kansas, as well as the community hospital of Mt. Carmel Medical Center in Pittsburg, Kansas.

I am here today representing not only Via Christi Health System, but the Kansas Hospital Association (KHA) as well, an organization which represents 125 community hospitals located throughout the state. All these hospitals are speaking with one voice in favor of passage of Senate Bill 245, which addresses the hospital lien law.

Lien Law History

It may be helpful to give you a short legislative history of the lien law in the State of Kansas. The first lien law was enacted in 1939 and allowed a hospital a lien in an amount not to exceed $200. Twelve years later, in 1951, the legislature more than tripled the amount of the lien to $700, in recognition of rising health care costs and inflation. Six years later, in 1957, another increase was given resulting in the lien amount more than doubling to $1,500. The last modification to the lien law occurred 25 years ago, in 1972. That modification brought the lien amount to $5000. While health care costs and inflation have driven the cost of health care to unprecedented levels over the past 25 years, the lien amount has remained at the $5000 limit.

Joint Support for Senate Bill 245

Senate Bill 245 provides a long overdue modification to the hospital lien amount and the hospitals of Kansas are supportive of the language of this Bill. Unlike past years, however, it is not only the hospitals of Kansas that are supportive of the modifications proposed, but the Kansas Trial Lawyers Association (KTLA), as well, support the proposed changes. The proposed language was co-drafted and approved by both organizations and both organizations urge your support and approval of the Bill.

The revisions proposed to the current lien law by Senate Bill 245 are fair, equitable and long overdue. Moreover, they will bring Kansas in line with the lien laws of our surrounding jurisdictions.

Conclusion

The Senate Bill before you was drafted in a cooperative spirit and with the intent of creating equity and fairness between a patient injured by reason of an accident (other than

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workers compensation) and the hospitals which must provide medical services. We urge your support and the passage of Senate Bill 245.

If the Committee desires any additional information, please feel free to contact me or the Kansas Hospital Association.

Roberta R. Johnson
Associate General Counsel
Via Christi Health System
1109 North Topeka
Wichita, Kansas 67214
(316-268-5107)

KANSAS TRIAL LAWYERS ASSOCIATION

Lawyers Representing Consumers

February 20, 1997

TO: Senate Public Health and Welfare Committee
Sandy Praeger, Chair

FROM: Terry Humphrey
Executive Director

SUBJECT: SB 245 - Concerning the Hospital Lien Bill

Since 1939 Kansas has had a hospital lien law which is codified at K.S.A. 65-406 et seq. This statute creates a lien against an injured victim's recovery of monetary damages for unpaid hospital charges incurred by the victim as a result of the wrongdoer's fault.

As originally enacted in 1939, the statutory lien was limited to reasonable and necessary hospital charges of not more than $200.00 for emergency services. In 1951 the statute was broadened to include all reasonable and necessary hospital charges not to exceed $700.00. The lien ceiling was raised to $1,500.00 in 1957 and $5,000.00 in 1972.

The Kansas Hospital Association (KHA) has voiced concern that the $5,000.00 lien cap has caused a hospital shortfall in certain instances where the victim's recovery was arguably sufficient to pay all of the victim's actual damages including hospital charges. This concern prompted introduction of Senate Bill 577 in the 1996 legislature which, as originally introduced, contained an unlimited hospital lien. SB 577 did not pass in the House and was never enacted. The KHA has renewed its effort to increase the $5,000.00 lien cap in the 1997 legislature.

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Terry Humphrey, Executive Director

Jayhawk Tower • 700 SW Jackson, Suite 706 • Topeka, Kansas 66603-3758 • 913.232.7

E-Mail: triallaw @ ink.org

The Kansas Trial Lawyers Association (KTLA) has expressed concern that an unlimited hospital lien could result in a harsh, unjust outcome for the injured victim in many cases. Multiple damages and losses are often sustained by the victim or the victim's surviving family including past and future hospital and medical expenses; lost wages; impairment of the victim's capacity to work and earn a living in the future; permanent disability or disfigurement; funeral expenses; loss of the victim's performance and contribution of household services to the family; property damages; pain and suffering; and other items.

Sometimes the victim's actual damages, including hospital charges, are greater than the victim's recovery, for example, the wrongdoer may have insufficient liability insurance coverage to fairly compensate the victim for the harm inflicted. In such a situation an unlimited hospital lien could exhaust the victim's recovery to the exclusion of compensation for the victim's other damages and losses.

Mindful of the other association's concern in this area, the KHA and KTLA have mutually developed compromise language for SB 245 which accomplishes the following:

1. Hospitals will be allowed to assert a lien unlimited in amount.

2. Liens of $5,000.00 or less and the first $5,000.00 of liens greater than $5,000.00 shall be fully enforceable as they are under present law.

3. Lien sums above $5,000.00 shall only be enforceable to the extent their

enforcement constitutes an equitable distribution of the recovery under the circumstances. If a hospital and an injured victim cannot agree on what constitutes an equitable distribution under the circumstances, the matter is submitted to a court for determination. This procedure allows the court to fashion an equitable distribution of the recovery based upon all prevailing factors including the amount of the hospital lien, the nature and extent of the victim's actual damages and the amount of the recovery.

KHA and KTLA jointly endorse the compromise language.

The University of Kansas Medical Center

School of Medicine
Department of Anesthesiology

Anthony L. Kovac, M.D.
Associate Professor
Medical Director,
Respiratory Therapy Services

TESTIMONY ON SENATE BILL 242
BEFORE THE SENATE PUBLIC HEALTH & WELFARE COMMITTEE
FEBRUARY 20, 1997

Madam Chair,
Members of the Committee,

My name is Dr. Anthony Kovac. I have been an associate professor in the Department of Anesthesiology on staff at the University of Kansas Medical Center for the last 16 years. I have been Medical Director of both the Respiratory Therapy Services department of the University of Kansas Medical Center and the Kansas Respiratory Care Society (KRCS) for the last five years. I meet and work with Respiratory Therapists on a daily basis, and I wish to speak in favor of upgrading the Respiratory Therapist's credential to licensure.

The goal of any healthcare credentialing process is to establish a minimum standard of achieved competency on the part of a provider in order to protect the public from harm from unqualified individuals.

To better understand the seriousness of this issue, one has to have an understanding of the vast scope of responsibility and services that Respiratory Therapists provide. Respiratory Therapists are unique in that they deal with patients in virtually all patient care settings because their area of expertise is the respiratory system, which can be immediately life-threatening regardless of where the patient may be. As respiratory system specialists, Respiratory Therapists receive special training in emergency airway management, mechanical life support, and the treatment of both sudden and chronic respiratory problems, such as asthma and chronic obstructive pulmonary disease. Respiratory Therapists are critical members of hospital wide and emergency room resuscitation teams, critical care teams, trauma teams, and any other system team developed to deal with airway problems. They deal with all types of patients, from the moment of delivery of premature infants to long-term home care for individuals suffering from chronic pulmonary diseases, such as emphysema and chronic bronchitis. When a sudden asthma attack strikes, it is the emergency room physician and the respiratory therapist who are most needed to provide appropriate, corrective care. Respiratory Therapists are also recognized experts in very complex pulmonary function diagnostic laboratory

Senate Public Health & Welfare
Date: 2-20-97
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3901 Rainbow Boulevard, Kansas City, Kansas 66160-7415 • (

procedures, such as pulmonary function testing, that detect hidden lung disease and give the physician an accurate description of both the nature and the severity of the disease. Respiratory Therapists obtain samples of arterial blood for oxygen and chemical analysis and perform diagnostic sleep apnea studies. They administer respiratory medications under the prescription of a physician. They provide home care to countless individuals, providing everything from supplemental oxygen to home mechanical ventilation. They assess and recommend ongoing respiratory therapy to physicians on all types of patients, from infants to the elderly, who suffer from some type of respiratory disease. Routinely a Respiratory Therapist must make quick decisions given certain patient circumstances, and many times these decision are life-saving in nature, requiring instant and appropriate responses with no time for consultation. Ladies and gentlemen, Respiratory Therapists are nationally recognized health care professionals specializing in the delivery of very sophisticated and life-saving services.

To date, thirty-five (35) states have full licensure of Respiratory Therapists. The states surrounding Kansas, except Colorado, have licensure, and Colorado is in the process of putting a bill together.

The existing credential for Respiratory Therapists is Registration. Quite simply, this is title protection only. As long as one does not call oneself a Respiratory Therapist, one can be placed into a position to provide these services. Thus, consumers have no assurance that a trained and competent individual is providing for their care. In life-threatening situations, this could prove to be fatal, and in lesser circumstances this would prove to be very expensive due to improper, unsafe, or the very least, ineffective therapy, thus prolonging a patient's stay in a hospital.

Some individuals may make the assumption that applicants requesting a change in their respective credentialing or scope of practice are doing this to reflect an enhanced economic benefit subsequent to their requested change. I believe that this simply is not true in this case. Consider the following: A system already exists to regulate the credential (the Board of Healing Arts), and is fully funded by Respiratory Therapist fees. Not one therapist would be legislated out of a job because a grandfather clause in the bill will allow these individuals who have been working since the original registration act to continue to work. Salaries will not go up as licensure vs. Registration will not affect wages because the criteria for legally qualified Respiratory Therapists will remain the same: the passing of a national board exam. Respiratory Therapists can only provide care under the express prescription of a physician, and this will not change. Finally, the bill recognizes other credentialed health care providers and allows these individuals to perform respiratory care procedures if it is in their scope of practice and they were appropriately trained. This takes us back to the original premise. Respiratory Therapists seek a change in their credential

because they want to enhance the quality of caregivers and protect the public from unqualified practitioners. It is up to the state to ensure its citizens are protected, and if a profession seeks to upgrade its professional standards, one should not automatically assume it is for economic gain. This is simply a patient protection issue. The gain to their profession is identical to the gain to the consumer, one of eliminating unscrupulous and untrained individuals. As healthcare expands more into the home and long-term care settings, it is more critical than ever that only qualified individuals are allowed to provide this care.

The Kansas Respiratory Care Society endorses a healthcare delivery system that meets the criteria of reduced cost, access to qualified practitioners, and the elimination of "turf" boundaries for other qualified practitioners. We feel that this bill accomplishes this goal.

Thank you for allowing me to provide you with this testimony.

Anthony L. Kovac MD

Anthony L. Kovac, MD
Medical Director, Kansas Respiratory Care Society
Medical Director, Respiratory Therapy Services
Associate Professor of Anesthesiology
University of Kansas Medical Center

KANSAS MEDICAL SOCIETY

February 20, 1997

To: Senate Public Health and Welfare Committee

From: Meg Henson
Director of Government Affairs

Subj: SB 242 - Respiratory Therapy

The Kansas Medical Society appreciates the opportunity to testify today in support of SB 242 relating to respiratory therapists. The bill would change the level of credentialing for RTs from registration to licensure.

Respiratory therapists play an important role in the health care system, working closely with physicians in a number of different settings including hospitals, clinics and nursing homes to provide respiratory care services. They perform complex tasks which, in many cases, are critical to the overall well-being of patients. Many physicians rely on RTs to provide appropriate and safe care to their patients in these settings. KMS believes that licensure of RTs would help to ensure that patients receiving these services have the requisite education and training necessary to provide safe and effective care.

Respiratory therapists work under the supervision of physicians, and it critical that this relationship be preserved if RTs become a licensed group. KMS is satisfied that the language of this bill preserves that physician-supervised relationship. The definition of "respiratory therapy" plainly states that is a profession whose members practice under the supervision of and with the prescription of a physician. The bill also includes a definition of "qualified medical director" and states that he or she is responsible for the quality of RT services and ensuring that RT care be ordered by a physician.

Thank you for considering our comments on this issue. I will be happy to answer questions.

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Western Kansas office • 311 E 25th St. • Hays KS 67601 • 913.625.8215 • 800.2

Senate Public Health and Welfare
Date: 2-20-97
Attachment No. 6

Memorandum

Donald A. Wilson
President

TO: Senate Public Health and Welfare Committee

FROM: Kansas Hospital Association; Tom Bell, Senior Vice President/Legal Counsel

RE: Senate Bill 242

DATE: February 20, 1997

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 242, which would grant licensure status to "respiratory care practitioners". This is not a new issue to come before state policymakers. In 1984 the Kansas Respiratory Care Society submitted an application to the Kansas Department of Health and Environment requesting they be licensed by the state. Subsequently, the 1985 Kansas Legislature passed a registration law. Then in 1993, the same group submitted an application to KDHE requesting licensure again. After consideration, the Secretary of that agency found that the current registration law is the appropriate level of credentialing and recommended that no legislative action be taken.

Before discussing the provisions of SB 242, it is appropriate to review the statutory criteria that is to be applied when a particular health care provider group seeks credentialing by the state. Our statutes state that credentialing by the state is only appropriate when the following findings are made:

(1) The unregulated practice of the occupation or profession can harm or endanger the health, safety or welfare of the public, and the potential for such harm is recognizable and not remote;

(2) the practice of the occupation or profession requires an identifiable body of knowledge or proficiency in procedures, or both, acquired through a formal period of advanced study or training, and the public needs and will benefit by assurances of initial and continuing occupational or professional ability;

(3) if the practice of the occupation or profession is performed, for the most part, under the direction of other health care personnel or inpatient facilities providing

Senate Public Health and Welfare
Date: 2-20-97
Attachment No. 7

KANSAS BOARD OF HEALING ARTS

BILL GRAVES
Governor

LAWRENCE T. BUENING, JR.
Executive Director

235 S. Topeka Blvd.
Topeka, KS 66603-3068
(913) 296-7413
FAX # (913) 296-0852

MEMORANDUM

TO: Senate Committee on Public Health and Welfare

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 20, 1997

RE: **SENATE BILL NO. 242**

Senator Praeger and members of the Committee, thank you for allowing me the opportunity to appear before you on behalf of the State Board of Healing Arts regarding Senate Bill No. 242. The purpose of my appearance today is to oppose favorable consideration of this bill.

Senate Bill No. 242 is similar to 1996 House Bill No. 2765 for which I appeared on behalf of the Board to provide information, but I clearly indicated the State Board of Healing Arts had taken no position at that time. Since 1993, I have been aware of the respiratory therapy profession's desire to obtain licensure and, until the past year, have worked closely with members of the Kansas Respiratory Care Society to develop statutory language that would enable licensure in a manner which could be administered by the Board with minimal fiscal impact. However, the State Board of Healing Arts, when it met February 15, 1997, and reviewed the provisions of Senate Bill No. 242 determined by unanimous vote to oppose this bill.

MEMBERS OF BOARD
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HAROLD J. SAUDER, D.P.M., INDEPENDENCE
EMILY TAYLOR, LAWRENCE

First, the State Board of Healing Arts, since its creation 40 years ago, has only licensed individuals who qualify to use the term "Doctor" in the health care setting. In 1957, the Board was created to regulate the professions of medicine and surgery, osteopathic medicine and surgery, and chiropractic. Each of these professions had earned the degree of doctor through their educational experiences. In 1975, by Executive Reorganization Order No. 8 issued by the Governor, the State Podiatry Board of Examiners was abolished and the powers, duties and functions transferred to the Board. Each of these licensed professions has the ability to independently examine, diagnose and treat patients without the intervention or supervision of any other health care professional. On the other hand, the other seven professions regulated by the Board cannot independently diagnose and treat individuals without authority from a licensee of the Board. This two-tier credentialing system has separated independent practice, i.e. licensure, from dependent practice, i.e. registration.

Secondly, all currently registered individuals under the jurisdiction of the Board can receive temporary permits without having met all the requirements for permanent registration by passing the required examinations. Senate Bill No. 242 would continue to allow this for respiratory therapists. See Section 7 on page 5, lines 35-41. On the other hand, all currently licensed doctors of the State Board of Healing Arts must be fully qualified to receive a permanent license, including passage of all required examinations, before being issued a temporary permit.

Finally, according to a computer search done by one member of the Board, the terms "licensee of the healing arts", "licensed to practice the healing arts", and "licensed by the healing arts board" appears 111 times in the Kansas statutes. K.S.A. 40-3103, as an example, specifically refers to "health care rendered by practitioners licensed by the board of healing arts...". There is a concern on behalf of the Board that licensing respiratory therapists would create a confusion on behalf of the citizens of this state as to the scope of practice of this profession even though Senate Bill No. 242 at page 1, lines 19-21 provides that practices of respiratory therapists can only be performed "under the supervision of and with the prescription of a licensed physician".

As to the specifics of the bill itself, while the term "qualified medical director" is defined on page 2, lines 28-36, that term is never used in either the existing language under the respiratory therapy act or in any proposed amendments thereto. The sentence commencing at page 4, line 15 makes little sense.

In conclusion, the State Board of Healing Arts, as the regulatory body for respiratory therapists, urges that this bill be recommended unfavorably for passage. Thank you again for the opportunity to appear before you in opposition to this bill and I would be happy to respond to any questions any of the committee members might have.

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

WRITTEN TESTIMONY PRESENTED TO

THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

SENATE BILL 242

The department provides this written informational testimony concerning the history of the topic addressed by Senate Bill 242.

In 1983 applications for credentialing of health care personnel in Kansas was the responsibility of the Statewide Health Coordinating Council (SHCC). Under that body's jurisdiction, an application for the licensure of the practice of respiratory care in Kansas was first submitted January 11, 1983. During the subsequent months, a technical review committee was convened and evidence was gathered through hearings and applicant-supplied materials and testimony in accordance with the criteria recognized at that time. The result of these deliberations was a recommendation for denial of credentialing by the technical committee and the SHCC. In 1985, the legislature passed a registration law for the respiratory therapists in Kansas.

In 1993 the Kansas Respiratory Care Society applied for a change in the level of credentialing; another technical review committee conducted its responsibilities in accordance with the Credentialing Act (Kansas Statutes Annotated 65-5001 et seq.). The result of the review indicated that the applicant group did not meet the criteria necessary to be recommended for licensure. At issue was the determination by the review committee that there was not evidence to convince the committee that licensure would prohibit the 'harm' to the public that was identified by the applicant group, one of the licensing criteria used. The Secretary of Health and Environment concurred with the committee's decision. Even with these findings, the Kansas Respiratory Care Society introduced House Bill 2765 to the 1996 Legislature which was not approved. Senate Bill 242 and House Bill 2765 are substantively the same as the 1996 proposed bill.

The Credentialing Act has been the topic of much consideration during previous legislative sessions. This bill and its history are relevant to the intent and purpose of the Credentialing Act. The applicant group desires an elevated level of credentialing which has twice been found under statutory review to be unnecessary.

Presented by: Lesa Bray, Director
Health Occupations Credentialing
February 20, 1997

Senate Public Health and Welfare
Date: 2-20-97
Attachment No. 9

Kansas State Board of Nursing

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Patsy L. Johnson, R.N., M.N.
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To: The Honorable Senator Sandy Praeger, Chairperson
and Members of the Public Health & Welfare Committee

From: Patsy L. Johnson, M.N., R.N., A.R.N.P.
Executive Administrator
Kansas State Board of Nursing

Date: February 20, 1997

Re: SB 242

Thank you for allowing me to present testimony on SB 242 for the Board of Nursing.

The Board of Nursing is supportive of licensure for respiratory therapists. The Board proposes one deletion in Section 1 (b)(4). See Balloon 1. The Board opposes respiratory therapists inserting and maintaining indwelling arterial catheters. We believe this is beyond what is needed for their practice. There is reference to collection of specimens of blood on page 2, line 16. This would allow respiratory therapists to draw blood for arterial blood gases.

The Board of Nursing asks that you act favorably upon SB 242 with the amendment that has been proposed.

Thank you.

Senate Public Health and Welfare
Date: 2-20-97
Attachment No. 10

Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Patricia McKillip, R.N., Ph.D.
Education Specialist
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Diane Gly
Practic
29

296-4325

Balloon

accordance with the prescription of a physician: Administration of medical gases, exclusive of general anesthesia; aerosols; humidification; environmental control systems ~~and~~ ~~baromedical~~ ~~therapy;~~ ~~pharmacologic~~; *transcription and implementation of written or verbal orders of a physician pertaining to the practice of respiratory care; the implementation of respiratory care protocols as defined by the medical staff of the institution; changes in treatment pursuant to the written or verbal orders of a physician or the initiation of emergency procedures under the regulations of the board or as otherwise permitted in this act. The administration of pharmacological* agents related to respiratory care procedures; mechanical ~~or~~, physiological, ventilatory *or circulatory* support; bronchopulmonary hygiene; cardiopulmonary resuscitation; maintenance of the natural airways; insertion ~~*and maintenance of indwelling arterial catheters*~~ *and maintenance of artificial airways* without cutting tissues ~~and~~ ~~maintenance~~ ~~of~~ ~~artificial~~ ~~airways~~; diagnostic and testing techniques required for implementation of respiratory care protocols; collection of specimens of blood; collection of specimens from the respiratory tract; analysis of blood gases and respiratory secretions, *and electrolytes; and collection and analysis of electrophysiological data.* — delete

~~(5)~~ ~~The transcription and implementation of the written and verbal orders of a physician pertaining to the practice of respiratory therapy.~~

(c) "Respiratory therapist" means a person who is ~~registered~~ *licensed* to practice respiratory therapy as defined in this act.

(d) "Person" means any individual, partnership, unincorporated organization or corporation.

(e) "Physician" means a person *who is* licensed *by the board* to practice medicine and surgery.

(f) "Qualified medical director" means the medical director of any inpatient or outpatient respiratory care service, department or home care agency. The medical director shall be a physician who has interest and knowledge in the diagnosis and treatment of respiratory problems. This physician shall be responsible for the quality, safety and appropriateness of the respiratory services provided and require that respiratory care be ordered by a physician who has medical responsibility for the patient. The medical director shall be readily accessible to the respiratory care practitioner.

Sec. 2. K.S.A. 65-5503 is hereby amended to read as follows: 65-5503. The board, ~~in the manner~~ *as* hereinafter provided, shall administer the provisions of this act.

Sec. 3. K.S.A. 65-5504 is hereby amended to read as follows: 65-5504. (a) There is established a respiratory ~~therapist~~ *care* council to advise the board in carrying out the provisions of this act. The council shall consist of ~~five~~ *seven* members, all citizens and residents of the state of