Approved: February 1, 2001
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on January 25 in Room 210 Memorial Hall

All members were present except: Rep. Willa DeCastro, Excused
Rep. Brenda Landwehr, Excused
Rep. Dale Swenson, Excused

Committee staff present: Dr Bill Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Susan Linn, Executive Director, Board of Pharmacy
Camille Nohe, Attorney General's Office
Matt All, Insurance Commissioner's Office

Others attending: See Attached Sheet

The Chairperson announced "Questions a Legislature Should Ask" was distributed to the sub-committee on licensing.

The Chairperson stated he believed all the members received letters about attending a dinner co-sponsored by the House and Senate Insurance Committees, Heath and Human Services and Senate Health and Public Welfare Committees. It was announced the other day that we would not be a part of sponsoring those dinners. As far as the committee is concerned that is still true, as individual members, you however, if you choose to go may do so. It is just that the committee is not a sponsor or approving of that. The cost would be recorded.

The Chairperson asked if there were any bill introductions and stated they would be grouped for introduction.

Representative Showalter conceptually introduced a Board of Cosmetology bill.

Mary Blubaugh MSN, RN, requested bill introduction that would amend several statutes in the Nursing Act.

The Chairperson stated the bill would be introduced without objection.

Susan Linn, Executive Secretary, Board of Pharmacy, briefed the committee on confidentiality. Ms. Linn stated Dr. Curry, Wichita, was concerned patients were going to other physicians and having multiple prescriptions filled by different pharmacies then selling them on the street. Dr. Curry thought the solution to this problem would be to require all pharmacists be linked via computer and asked the Board of Pharmacy to put something like this in place. This would enable all pharmacists to have patient information available before filling a prescription.

There would be many potential problems with this, one would be how to get all pharmacies on one computer system that communicated and how and who would maintain it. A greater problem would be confidentiality and security. The Board of Pharmacy does take breeches of confidentiality very seriously (Attachments 1 & 2).

Camille Nohe, Assistant Attorney General, Legal Opinions and governmental Counsel Division, briefed the committee regarding confidential and privileged communications.

Confidentiality refers to statutes, unprofessional conduct regulations and/or professional ethics that denote

an obligation not to reveal client information unless permitted or mandated by law. A breach of confidentiality may result in disciplinary action by the licensing body and/or a lawsuit by the client. Confidential communications are not, however, necessarily privileged communications.

A privilege refers to a statutorily created right that exempts clients, under most circumstances, from having their confidential communications revealed in a court proceeding without first granting permission to do so.

SB 399 was crafted by the Legislative Mental Health Task Force to create a confidential/privileged communication act for individual licensed mental health professional that would parallel the Confidential Communications and Information Act (applicable to mental health facility clients). While that bill did not move forward last year, the Behavioral Sciences Regulatory Board has established a Committee to carefully review the proposal. Hopefully next year the Board will come forward with a refined proposal that will engender support from interested parties (Attachment 3).

Matthew D. All, Assistant Commissioner, Kansas Insurance Department, briefed the committee on the privacy of Kansans health information as an insurance regulator, and not a regulator of doctors, hospital, pharmacists or many of the other actors in the health industry. The insurance industry is vital to the issue of health privacy, and this issue occupies our office a great deal. We believe that Kansans should be able to control their health information.

New regulations issued by the federal government will, in time, provide some protection for Kansans' health information under certain circumstances. These regulations were issued by the U.S. Department of Health and Human Services pursuant to a mandate in the health Insurance Portability and Accountability Act of 1996. This Act, commonly known as HIPPA, required Congress to pass comprehensive health privacy standards by August 1999. Because Congress failed to meet that deadline, the job fell to the U.S. Department of Health and Human Services.

The HIPPA regulations were issued in draft form in February 2000, then final form in December. They are highly complex. These regulations are a step forward, but do not take affect until February 2003, and clearly do not apply to all of the various actors in the health and insurance industries who possess health information. Broader and more immediate protection is needed (Attachment 4).

The meeting adjourned at 2:10 p.m. and the next meeting will be January 29.

HEALTH AND HUMAN SERVICES

DATE January 25, 2001

NAME	REPRESENTING
Susan G. Linn	Board of Pharmacy
Vicki Schmidt	Bd of Rx
Camille Nohe	AG
Phyllis Gilmore	BSRB
Kevin Barone	Hein/Weir Chtd.
Karen Ann Lower	KANP
Bob Williams	Ks. Pharmacists Assoc
Bob Alderson	" " "
Larry Buening	Bd of Healing Arts
Chip Wheelen	Osteopathic Association
Allison Parsons	Federico Consulting
Scott Brunner	DOB
Mary Moore	Ks Psych. Assoc
Marijo Teare Rooney	KS Psych Assoc
Chris Collins	Kansas Medical Society
Whitney Damron	KS Psychological Assn.
Corrie Mullen	Kathy Damron & Assoc
Brad Smoot	BCBS
Mike Huttles	Ks. Gov't Consulting
Michelle Peterson	PhRMA
Kevin Davis	Am Family Ins.

Kansas State Board of Pharmacy

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BILL GRAVES
GOVERNOR

Briefing on Kansas State Board of Pharmacy

Representative Boston and Members of the Committee:

I am Susan Linn, the Executive Secretary of the Board of Pharmacy. Thank you for giving me this opportunity to introduce myself and brief you on a few issues important to the Board of Pharmacy.

The Board of Pharmacy licenses over 8,000 pharmacies, pharmacists, drug manufacturers and distributors, research and teaching facilities and retail stores. I have a staff of two full time office personnel, and three pharmacy inspectors. We are a fee fund agency, which means the licensees pay for the services we provide. Our pharmacy inspectors inspect all pharmacies at least once a year and take this opportunity to educate pharmacists on possible violations of the law. We also investigate complaints we receive from consumers and government agencies.

Recently, Representative Boston contacted me about an issue concerning communication from a physician in Wichita. I have provided you with copies of the letter.

In the letter, the physician expressed concern that his patients were going to other physicians and having multiple prescriptions filled by different pharmacies. The physician was concerned these drugs were then sold on the street. Dr. Curry thought that the solution to this problem would be to require all pharmacists be linked via computer. This would enable all pharmacists to have patient information available before filling a prescription. Dr. Curry asked the Board of Pharmacy to put something like this in place.

Although I appreciate the physicians' difficulty in knowing what his patients were being prescribed by other doctors, I see many potential problems with what Dr. Curry suggests. Not the least of these problems, would be how to get all pharmacies on one computer system that communicated and how **and**

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who would maintain it. I think that issue, plus the costs involved, would make his idea unworkable. There may also be some antitrust issues if the State Board mandated the use of one vendor's software.

An even greater problem would be confidentiality and security. People expect that if they provide confidential information to a pharmacy, it will not be shared with the entire pharmacy world. I have also included in my handouts a copy of the Kansas Statute in the Pharmacy Act pertaining to patient confidentiality. Only the patient can waive this confidentiality.

If pharmacies would have to download this information via the Internet, which would seem to be the only practical means possible, I believe you could have insurmountable security issues. If people can hack into the Pentagon computers, they will certainly be able to hack into Kansas pharmacy computers. This could severely compromise confidentiality, but also raise issues of anyone being able to electronically manipulate the patient and pharmacy records.

One of our responsibilities is to investigate complaints for violations of the law. In my short time with the Board of Pharmacy, we have had two complaints alleging breech of confidentiality. Both of these had to do with information required by insurance companies and did not require anything beyond a patient's name. In the system Dr. Curry envisions, consumer complaints would escalate and our job of protecting the public would become overwhelming.

I understand that there are safeguards in place that pharmacists are required to use if they suspect anything about the prescription, from calling the physician to notifying local DEA agents. I'm not sure much more can be done for those people who do not even provide a correct name or address. I do know that the Board of Pharmacy does take breeches of confidentiality very seriously.

I will try to answer any questions you have.

such act would have been enacted had such unconstitutional or invalid provisions not been included. History: L. 1953, ch. 290, § 35; L. 1967, ch. 342, § 6; L. 1975, ch. 319, § 45; July 1.

65-1650. Regulation of advertising of prescription-only drugs; exceptions and exclusions. The board of pharmacy is hereby authorized to regulate the advertising, but not the prices or discounts, of prescription-only drugs. The provisions of this section shall not be construed to:

(1) Authorize the state board of pharmacy to require, regulate or prohibit the posting within a pharmacy of the current charges by such pharmacy for prescription-only drugs and services, nor,

(2) restrict the offering of discounts on prescription-only drugs.

History: L. 1974, ch. 252, § 5; L. 1975, ch. 319, § 35; July 1.

65-1651. Sections part of and supplemental to pharmacy act. The provisions of K.S.A. 65-1627a to 65-1627h, inclusive, 65-1628a, 65-1628b and 65-1650, are hereby declared to be a part of and supplemental to the pharmacy act of the state of Kansas.

History: L. 1975, ch. 319, § 46; July 1.

65-1652. Immunity from liability in civil actions for reporting, communicating and investigating certain information concerning alleged malpractice incidents and other information; conditions. (a) No person reporting to the board of pharmacy under oath and in good faith any information such person may have relating to alleged incidents of malpractice or the qualifications, fitness or character or a pharmacist shall be subject to a civil action for damages as a result of reporting such information.

(b) Any state, regional or local association of pharmacists and the individual members of any committee thereof, which in good faith investigates or communicates information pertaining to the alleged incidents of malpractice or the qualifications, fitness or character of any pharmacist to the board of pharmacy or to any committee or agent thereof, shall be immune from liability in any civil action, that is based upon such information or transmittal of information if the investigation and communication was made in good faith and did not represent as true any matter not reasonably believed to be true.

(c) This section shall be a part of and supplemental to the pharmacy act of the state of Kansas. History: L. 1976, ch. 261, § 5; L. 1986, ch. 231, § 31; June 1.

65-1653. References to registered pharmacists deemed to apply to licensed pharmacists. (a) Whenever registered pharmacist, or words of like effect, is referred to or designated by a statute, rule and regulation, contract or other document in reference to a pharmacist registered under the pharmacy act of the state of Kansas, such reference or designation shall be deemed to apply to a licensed pharmacist under this act.

(b) This section shall be part of and supplemental to the pharmacy act of the state of Kansas. History: L. 1986, ch. 231, § 38; June 1.

65-1654. Privileged communications. (a) The confidential communications between a licensed pharmacist and the pharmacist's patient and records of prescription orders filled by the pharmacist are placed on the same basis of confidentiality as provided by law for communications between a **physician** and the physician's patient and records of prescriptions dispensed by a **physician.** Nothing in this subsection shall limit the authority of the board or other persons, as provided by law, from inspecting the book or file of prescription orders kept by a pharmacy or firm performing any duty or exercising any authority as otherwise provided by law.

(b) This section shall be part of and supplemental to the pharmacy act of the state of Kansas. History: L. 1989, ch. 193, § 3; July 1.

65-1655. Information required of applicant for registration to distribute at wholesale any drugs; factors in reviewing qualifications of applicants; denial of application if not in public interest; qualifications of personnel; rules and regulations. (a) The board shall require an applicant for registration to distribute at wholesale any drugs under K.S.A. 65-1643 and amendments thereto, or an applicant for renewal of such a registration, to provide the following information:

(1) The name, full business address and telephone number of the applicant;

(2) all trade or business names used by the applicant;

(3) addresses, telephone numbers, and the names of contact persons for all facilities used by the applicant for the storage, handling and distribution of prescription drugs;

(4) the type of ownership or operation of the applicant;

(5) the name of the owner or operator, or both, of the applicant, including:

(A) If a person, the name of the person;

Douglas W. Curry, M.D.
455 South Ridge Rd.
Wichita, Kansas 67209
Ph. 316-722-2222
Fax 316-729-4416

August 30, 2000

Director, Board of Pharmacies
State of Kansas, Topeka, Kansas 66612

Dear Sir,

I am a family physician who also does a fair amount of weight management and chronic pain management. I am currently practicing in the Wilbeck Clinic at 455 South Ridge Rd. in Wichita, Kansas. Over the last 6 years I have worked for Riverside Health System at the 61st Street Office and at the West Street office. I have also done a fair amount of emergency room duty in both Newton and El Dorado. Over this time period while working with patients in need of weight or pain management I have had a very significant problem of trying to determine which patients were legitimately seeking help and which patients were in fact seeking to obtain medication for the purposes of abuse or resale on the street. I have documented a number of patients who may indeed have some MRI or x-ray evidence suggesting they could have pain and are obtaining regular medication but when I check the levels of medication in their systems , they have none. I have reported these people to the proper legal authorities and have been told that they are so busy and swamped with other things that they are unable to really do anything to control this situation. The biggest problem with trying to manage the acquisition and sale of prescription narcotics in Sedgwick County seems to be related to the fact that almost every pharmacy in the county is set up individually on a computer basis so that it is not even possible for the individual physician to be able to check on a particular patient as to their prescription history and frequency. Therefore patients are filling multiple prescriptions at multiple pharmacies , selling it on the street and then harrassing several doctors to fill them again.

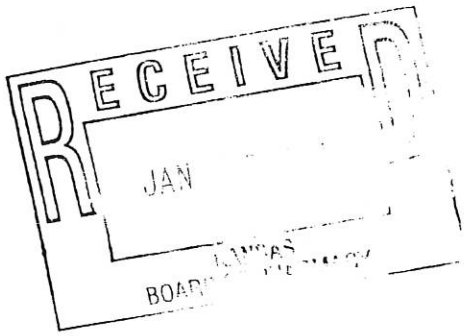
Prior to practicing in Kansas I practiced in Lincoln, Nebraska for many years and as early as mid 80's all of the pharmacies there were set up on one computer system whereby we could call one pharmacy and know what prescriptions a patient had filled at any pharmacy in the entire county. I do believe that if Sedgwick County were to be set up on a similar system it would eliminate a large portion of the problem that physicians have in knowing which patients are legitmate and which ones are trying to scam the system. It would help with the problem of legal medications that are being sold illegally on the streets and thus reduce the large number of patients that harrass the physicians involved in pain management.I have tried as an individual physician to approach

different pharmacies to see if there was not a way to implement a computer system with little success. Therefore I am asking for your help in considering this situation and seeking a solution to the problem. Thank you for any help you can give us.

Sincerely,

Douglas Curry 2nd

Douglas W. Curry, M.D.



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January 25, 2001

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Briefing to the House Health and Human Services Committee Regarding Confidential and Privileged Communications

Presented by Assistant Attorney General Camille Nohe

As an Assistant Attorney General in the Legal Opinions and Governmental Counsel Division, I have served as general counsel to the Behavioral Sciences Regulatory Board for about 8 years. I am presenting testimony on a topic that has been of concern to me for many of these years: the lack of consistency, clarity and difficulty in applying confidential and privileged communication statutes to clients of the various mental health professionals licensed by the Board.

As a preliminary matter, you should be aware of the legal distinction between confidential communications and privileged communications (although this distinction is at times blurred by the court decisions and legislative enactments).

Confidentiality refers to statutes, unprofessional conduct regulations and/or professional ethics that denote an obligation not to reveal client information unless permitted or mandated by law. A breach of confidentiality may result in disciplinary action by the licensing body and/or a lawsuit by the client. Confidential communications are not, however, necessarily privileged communications.

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A privilege refers to a statutorily created right that exempts clients, under most circumstances, from having their confidential communications revealed in a court proceeding without first granting permission to do so.

Privileged Communications

Clients of most licensed mental health professionals are protected by a statutory privilege that is "placed on the same basis as provided by law for those between an attorney and the attorney's client." These are clients of licensed Ph.D. psychologists, masters level psychologists, clinical psychotherapists, professional counselors, clinical professional counselors, masters social workers and clinical specialist social workers.

The problem here lies in the difficulty in applying a privilege designed for clients of lawyers to clients of mental health professionals. In relation to the exceptions, for example, the lawyer-client privilege exempts "a communication relevant to an issue between parties all of whom claim through the client, regardless of whether the respective claims are by testate or intestate succession or by inter vivos transaction." Clearly, this exception has no application to a therapist-client relationship.

Another example of the difficulty in applying the lawyer-client privilege to a therapist-client relationship was highlighted in a murder case that required a Kansas Supreme Court decision before it could proceed to trial. The problem was in the definition of "lawyer," which means "a person authorized, *or reasonably believed by the client to be authorized* to practice law...." In considering whether the lawyer-client privilege applied to a communication made to a person the client reasonably believed was a licensed professional counselor - but in fact was not - the Kansas Supreme Court began by saying, "The issue is simple. The answer is complex." Sixteen pages of analysis later, the Court concluded that the statutory professional counselor privilege "extends only to licensed counselors and not to someone the client reasonably believes to be a licensed counselor."

Thus the confession to a unlicensed person - but whom the client thought was licensed - was ultimately found admissible.

Additionally, with the privilege placed on the same basis as between an attorney and client, a licensed mental health professional must know the substance of the attorney-client privilege statute and the exceptions to that privilege - something in my experience these professional are not aware of.

Whether clients of associate and baccalaureate social workers and marriage and family therapists actually hold a privilege in relation to their confidential communications is not stated as explicitly as with the professions just discussed. Limitations on disclosure of information are statutorily established for clients of these groups and certain information is specifically not to be treated as privileged[1]. However, whether an actual privilege exists in relation to other communications presumably made in confidence is open to debate.

Confidential Communications

As with privileged communications, the spectrum across professional disciplines of what communications are considered confidential is inconsistent and lacking in relationship-specific clarity.

Kansas law provides that confidential relations and communications between licensed Ph.D. psychologists, masters level psychologists, clinical psychotherapists, professional counselors, clinical professional counselors, masters social workers, and clinical specialist social workers and their clients are also placed on the same as those between an attorney and client.

Pursuant to Kansas Supreme Court Rule 1.6, "Confidentiality of Information," an attorney

[1] E.g. information that pertains to criminal acts or violations of law.

is prohibited from revealing "information of a client unless the client consents" with 3 exceptions:

- to prevent the client from committing a crime;
- to comply with requirements of law or orders of any tribunal; or
- to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client."

Despite some additional exceptions within the unprofessional conduct regulations for each group of licensed mental health professionals (e.g. consent, mandatory reporting of child abuse, failure to disclose presents a clear and present danger to the health and safety of another), an argument can be made that the 3 lawyer-client exceptions are the only exceptions to client confidentiality. Needless to say, such ambiguity is not a desirable situation.

Additionally, as with privileged communications, for clients of associate and baccalaureate social workers and marriage and family therapists, disclosure of confidential information and the limitations/exceptions are statutorily established in the practice acts and are unrelated to attorney-client confidential communications.

The Confidential Communications and Information Act

To complicate matters even further, Kansas adopted the Confidential Communications and Information Act[2] that protects communications of patients of treatment facilities. That Act contains 14 exceptions to non-disclosure, all of which are specifically tailored to issues related to patients of a treatment facility - patients who are treated by a range of mental health professionals. These

[2]K.S.A. 65-5601*et seq.*

exceptions are for the most part inconsistent with the attorney-client exceptions (applicable to most mental health professionals) as well as with the lower level social workers and marriage and family therapist exceptions.

Assuming sound public policy supports confidentiality and a privilege for communications a client makes to a licensed provider of mental health services, in my opinion that confidentiality and privilege, and any exceptions, should be statutorily explicit and tailored to that relationship. In addition, such confidentiality and privilege, and any exceptions, should be consistent across professions so that clients have the same protection regardless of which mental health professional provides treatment or therapy. I believe that this approach would also benefit mental health centers employing a variety of mental health providers

The good news to all this is the problems pointed the way to the solution. 2000 SB 399 was crafted by the Legislative Mental Health Task Force to create a confidential/privileged communication act for individual licensed mental health professional that would parallel the Confidential Communications and Information Act (applicable to mental health facility clients). While that bill did not move forward last year, the Behavioral Sciences Regulatory Board has established a Committee to carefully review the proposal. Hopefully next year the Board will come forward with a refined proposal that will engender support from interested parties.

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Testimony on Health Privacy
Before the House Committee on Health and Human Services

MATTHEW D. ALL
Assistant Commissioner
Kansas Insurance Department
Thursday, January 25, 2001

To the Chairperson and the Members of the Committee:

Thank you for inviting me today to talk about the privacy of Kansans health information. This is a crucial issue in the new economy, and we appreciate being included in your discussion.

Because I am an insurance regulator, and not a regulator of doctors, hospitals, pharmacists or many of the other actors in the health industry, my comments will not be as universally applicable as the comments of some. But the insurance industry is vital to the issue of health privacy, and this issue occupies our office a great deal. And so I am glad that you have asked us to give our thoughts.

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Fundamentally, we believe that Kansans should be able to control their health information. We believe that this upholds basic Kansas values of individual integrity and dignity. We do not believe this is a Republican or Democratic or conservative or liberal issue. We believe Kansans of all types care about health privacy and deserve to have their information protected under the law.

Unfortunately, today Kansans' health information is vulnerable. There is no general, comprehensive Kansas statute prohibiting the disclosure of individually identifiable private health information. Although this has this has always been a problem, it is a more serious problem today, for as technology advances and managed care maintains its increased presence in the health market, information is more concentrated and easier to disseminate than ever before. Moreover, this new technology has aided the development of an industry centered around target marketing, in which marketers use demographic profiles to direct products to those people most likely to buy them. The existence of this industry makes individuals' personal health information even more valuable.

New regulations issued by the federal government will, in time, provide some protection for Kansans' health information under certain circumstances. These regulations were issued by the U.S. Department of Health and Human Services pursuant to a mandate in the Health Insurance Portability and Accountability Act of 1996. This act, commonly known as

HIPAA, required Congress to pass comprehensive health privacy standards by August 1999. Because Congress failed to meet that deadline, the job fell to the U.S. Department of Health and Human Services.

The HIPAA regulations were issued in draft form in February 2000, and then in final form last month. They are highly complex, and so I am not prepared to give you a full description of their contents. In general, however, they apply to health insurers and health care providers and require these persons to obtain consent in advance from patients in order to disclose personal health information outside of certain business exceptions.

Although these regulations are clearly a step forward, they do not take affect until February 2003, and clearly do not apply to all of the various actors in the health and insurance industries who possess health information. Broader and more immediate protection is needed.

We at the Kansas Insurance Department are grappling with health information privacy today because of another action by the federal government. In November 1999, Congress passed the Gramm-Leach-Bliley Act (GLBA). GLBA advanced the cause of "financial services modernization" by breaking down many of the Depression-era barriers between banks, securities firms, and insurance companies. In short—and I am leaving out lots of details in the interest of brevity—GLBA allows these various financial institutions to affiliate within the structure of a financial holding company.

In the face of the new financial conglomerates that GLBA allows, many became worried about how much consumer information would be concentrated, complied, and shared within a financial holding company structure, and then ultimately sold or shared to third parties. To address this issue, Congress adopted fairly modest privacy standards governing the use of consumers' personal information. Congress required these financial institutions to give their customers notice of their privacy policies, but then put the burden on consumer to take the affirmative step of "opting out" of disclosures to third parties. But even if consumers take that affirmative step to opt out, there is nothing consumers can do to prevent affiliated financial institutions from sharing their personal information.

Congress left it to federal banking and security regulators to issue regulations to implement these privacy standards under GLBA for banks and securities firms. But Congress left it to the states to issue regulations to implement these standards on insurance companies. Wisely, Congress explicitly allowed states to issue regulations or pass laws that offered consumers more protection of their personal information than the meager ones found in GLBA. State law that offers less consumer protection would be preempted.

To avoid having 50 different sets of privacy regulations under GLBA, the National Association of Insurance Commissioners (NAIC) decided to adopt a model regulation to provide uniform privacy standards for insurance

companies under GLBA. Commissioner Sebelius chaired the Privacy Working Group, which developed this model regulation. The final draft of this model regulation, which every insurance commissioner—Republican and Democrat, appointed and elected—voted for in September of last year, mirrors the federal regulation for financial information. That is, it has essentially the same opt-out standard for non-affiliated third parties.

But because insurance regulators are accustomed to dealing with institutions that possess health information—unlike banking or securities regulators or the banking-dominated forces in Congress that passed GLBA—insurance regulators understood the crucial distinction between financial information and health information. Although financial information can be sensitive, and most of us would like to keep it private, it is not nearly as sensitive as health information, which is far more fundamental to who we are as people, and can also be much more damaging if revealed.

Because of this distinction, the NAIC Model Regulation creates an "opt-in" system, in which the general rule is that insurance companies must obtain consent from consumers in advance if they want to disclose consumers' private health information. It provides broad business exceptions so that insurance companies can still offer the insurance products Kansans need without unnecessary paperwork and expense. But outside of those exceptions, if insurance companies want to sell, share, or disclose consumers' personal information, they must get consumers' consent in advance.

We have submitted a bill that has yet to be heard that would grant the commissioner the authority to adopt the NAIC Model Regulation. We expect that it will be heard in the House Insurance Committee in the next couple of weeks, perhaps with other proposals. Unfortunately, the alternative proposals we anticipate fail to provide sufficient protection of consumers' personal health information. And, what's more, these weaker approaches are more complicated and require more paperwork than the NAIC Model Regulation. We firmly believe that the approach we propose is the correct balance: it is simple, efficient and business friendly, but gives Kansans the protection they deserve for their personal health information.

But clearly, whatever happens in that debate, there will be much work to be done in this area. We hope and fully expect to be able to work with the members of this committee and others in the Legislature, both in this session and in the future, to help provide this important protection to Kansans.