Approved:
Date: February 26, 2002

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Sandy Praeger at 9:30 a.m. on February 20, 2002 in Room 234 N of the Capitol.

All members were present except:

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Ken Wilke, Office of the Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Brad Smoot, Blue Cross/Blue Shield
Rebecca Rice, Kansas Chiropractic Association
Ed McKenzie, D.C., Holton
Timothy D. Bolz, D.C., Topeka
Chip Wheelen, Kansas Association of Osteopathic Medicine
Larry Buening, Kansas Board of Healing Arts
Chris Collins, Kansas Medical Society
Bill Sneed, Health Insurance of America Association
Larrie Ann Lower, Kansas Association of Health Plans
Cheryl Dillard, Mid America Health

Others attending: See attached list.

Discussion and Action on SB 469 - State employees health plan; inclusion of additional entities

Brad Smoot, Blue Cross/Blue Shield, briefed the Committee on amendments in a balloon of **SB 469** which addressed the concerns of those entities offering testimony on the bill at the hearing on February 13th. (Attachment 1) Senator Teichman made a motion to adopt the amendments offered in the balloon of the bill, and that the Committee recommend **SB 469 as amended** favorable for passage, seconded by Senator Feleciano. The motion carried.

Hearing on SB 542 - Utilization review; limitation on issuance of certificate

Rebecca Rice, Kansas Chiropractic Association, expressed support for **SB 542** which would expand requirements for issuing certificates by the Insurance Commissioner to a utilization review organization that have providers licensed in Kansas. Ms. Rice introduced Ed McKenzie, D.C., Holton, who noted that the bill would make several changes in the claims review process to help protect patients seeking health care. He pointed out that requiring a reviewer to derive a majority of his income from his active practice makes that person subject to the same rules that he or she uses to review claims. Requiring the review to be licensed in the state of Kansas means that he or she should be familiar with the law of the state. (Attachment 2)

Timothy D. Bolz, D.C., Topeka, expressed his support for the bill and recommended that: (1) All organizations that use reviews be subject to provisions of this statute; and (2) The healthcare providers doing reviews must derive 60% of their income from the practice of their profession and provide proof of such income to the Kansas Insurance Commissioner's office annually as shown in his written testimony. (Attachment 3)

Chip Wheelen, Kansas Association of Osteopathic Medicine, expressed his support for **SB 542**. Mr. Wheelen noted that the bill would provide recourse to an injured patient, because the insurer's utilization reviewer would be licensed in Kansas and the injured patient could file a complaint to the Board of Healing

Arts. He noted that another important feature of the bill is the requirement that the reviewer be actively engaged in practice and that he or she not derive a majority of his or her income from peer review and witness fees. (Attachment 4)

Larry Buening, Kansas Board of Healing Arts, expressed his support for the bill by noting the importance of utilization review of health care services provided by Kansas health care providers on Kansas citizens be performed by providers who are licensed and actively practicing in Kansas. (Attachment 5)

Chris Collins, Kansas Medical Society, testified before the Committee in support of **SB 542**. In her written statement Ms. Collins noted that KMS does not support the concept that a similarly educated professional needs to conduct medical necessity determinations on all claims presented for payment. (Attachment 6)

Bill Sneed, Health Insurance of America Association, testified in opposition to the bill. He stated that there is no empirical evidence that Kansas licensees should be the only ones in the country capable of making determinations within a utilization review, and that such change would only damage an appropriate mechanism that is utilized in an effort to effectively keep health care costs down and insurance premiums affordable. (Attachment 7)

Also speaking in opposition to **SB 542** was Larrie Ann Lower, Kansas Association of Health Plans. Ms. Lower expressed two concerns: (1) whether this bill would require that an initial review of a claim be performed by a provider licensed in the state in the practice under review and also actively engaged in the practice of that licensed profession; and (2) whether this bill requires a utilization review of a pediatrician to be performed by a pediatrician and a cardiologist be reviewed by a cardiologist. She noted that KAHP would like the opportunity to clarify this issue with the proponents. (Attachment 8)

Cheryl Dillard, Mid America Health, commented that the two entities most frequently used by health plans for accreditation now are the National Committee for Quality Assurance and the Joint Commission on the Accreditation of Healthcare Organizations. She pointed out that to continue to name the Utilization Review Accreditation Commission accreditation as the only path to an exemption is to unfairly disadvantage plans that have chosen a different but equally rigorous path to achieving the highest standards. (Attachment 9)

After Committee discussion on the bill, the Chair requested staff present an overview of the Utilization Review Act and utilization review organizations next week to the Committee.

Adjournment

The meeting was adjourned at 10:30 a.m. The next meeting is scheduled for February 21, 2002.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2-20-02

NAME	REPRESENTING
Bill Snead	NIRA
Rick Guthrie	Health Midwest
EDWARD MCKENZIE, DC.	Kansas Chiropractic Association
Timothy Bolz, DC	Kansas Chiropractic Association
Kevin Barone	Hein Law Firm.
Kevin Davis	Am. Family Ins
Joe Wright	FARMERS INS
Marne Ann Rouser	KAAP
Sandy Jacquot	LKM
Chip Wheelen	Osteopathic Assoc.
Randy Allen	Ks. Assoc. of Counties
LARRY BUENING.	BD OF HEALING ARTS.
Linda McCaussey	Ks Ins. Dept
Jarod Jorbes	Ks. Ins. Dept.
Emil Sweet	BCBS
Cheryl Allard	Mid America Health
Larry W Peterson	Ks. Found. for Medical Care

Session of 2002

SENATE BILL No. 469

By Committee on Financial Institutions and Insurance

1-29

AN ACT concerning the state health care benefits program; concerning participation by local governmental entities in such program; amending K.S.A. 75-6501, 75-6506 and 75-6509 and repealing the existing sections.

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

Section 1. K.S.A. 75-6501 is hereby amended to read as follows: 75-6501. (a) Within the limits of appropriations made or available therefor and subject to the provisions of appropriation acts relating thereto, the Kansas state employees health care commission shall develop and provide for the implementation and administration of a state health care benefits program.

(b) The state health care benefits program may provide benefits for persons qualified to participate in the program for hospitalization, medical services, surgical services, nonmedical remedial care and treatment rendered in accordance with a religious method of healing and other health services. The program may include such provisions as are established by the Kansas state employees health care commission, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

(c) The Kansas state employees health care commission shall designate by rules and regulations those persons who are qualified to participate in the state health care benefits program, including active and retired public officers and employees and their dependents as defined by rules and regulations of the commission. In designating persons qualified to participate in the state health care benefits program, the commission may establish such conditions, restrictions, limitations and exclusions as the commission deems reasonable. *Such conditions, restrictions, limitations and exclusions shall include the conditions contained in subsection (d) of section 2, and amendments thereto.* Each person who was formerly elected or appointed and qualified to an elective state office and who was

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covered immediately preceding the date such person ceased to hold such office by the provisions of group health insurance or a health maintenance organization plan under the law in effect prior to August 1, 1984, or the state health care benefits program in effect after that date, shall continue to be qualified to participate in the state health care benefits program and shall pay the cost of participation in the program as established and in accordance with the procedures prescribed by the commission if such person chooses to participate therein.

(d) The state health care benefits program established under this act shall be effective on and after August 1, 1984.

Sec. 2. K.S.A. 75-6506 is hereby amended to read as follows: 75-6506. (a) The participation of a person qualified to participate in the state health care benefits program shall be voluntary, and the cost of the state health care benefits program for such person shall be established by the Kansas state employees health care commission.

(b) Periodic deductions from state payrolls may be made in accordance with procedures prescribed by the secretary of administration to cover the costs of the state health care benefits program payable by persons who are on the state payroll when authorized by such persons. Any such periodic payroll deductions in effect on an implementation date for biweekly payroll periods shall be collected in the manner prescribed by the secretary of administration.

(c) In the event that the Kansas state employees health care commission designates by rules and regulations a group of persons on the payroll of a county, township, city, special district or other local governmental entity, public school district, licensed child care facility operated by a not-for-profit corporation providing residential group foster care for children and receiving reimbursement for all or part of such care from the department of social and rehabilitation services, nonprofit community mental health center, as provided in K.S.A. 19-4001 *et seq.* and amendments thereto, nonprofit community facility for the mentally retarded, as provided in K.S.A. 19-4001 *et seq.* and amendments thereto, or nonprofit independent living agency, as defined in K.S.A. 65-5101 and amendments thereto, as qualified to participate in the state health care benefits program, periodic deductions from payrolls of the local governmental entity, public school district, licensed child care facility operated by a not-for-profit corporation providing residential group foster care for children and receiving reimbursement for all or part of such care from the department of social and rehabilitation services, nonprofit community mental health center, as provided in K.S.A. 19-4001 *et seq.* and amendments thereto, nonprofit community facility for the mentally retarded, as provided in K.S.A. 19-4001 *et seq.* and amendments thereto, or nonprofit independent living agency, as defined in K.S.A. 65-5101 and amendments thereto,

may be made to cover the costs of the state health care benefits program payable by such persons when authorized by such persons. All such moneys deducted from payrolls shall be remitted to the Kansas state employees health care commission in accordance with the directions of the commission.

(d) On and after July 1, 2002, whenever the Kansas state employees health care commission designates any entity listed in subsection (c) as qualified to participate in the state health care benefits program, such entity's participation shall be conditioned upon the following:

(1) At least 70% of such entity's employees shall participate in the state health care plan;

(2) ~~the amount~~ of the premium paid by the entity as the employer's share of the total amount of premium paid shall be equal to the ~~amount~~ paid by the state of Kansas for its employees;

(3) the entity shall not create, maintain or permit any exemption from participation in the state health care plan for such entity's employees;

(4) the rate charged to such entity shall be sufficient to pay for any administrative or underwriting costs incurred by the state employees health care commission.

Sec. 3. K.S.A. 75-6509 is hereby amended to read as follows: 75-6509. Commencing with the regular session of the legislature in 1985 and with each regular session of the legislature thereafter, the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, on the day the governor's budget report is submitted to the legislature, recommendations with respect to the state health care benefits program together with estimates of the cost of the program proposed by the commission, including a five-year projection of the cost of the program, *and the estimated cost of admitting each entity pursuant to subsection (c) of K.S.A. 75-6506 and amendments thereto*. Together with the recommendations submitted, the commission shall include alternatives for cost containment and benefit coverage for qualified persons for both the proposed program and the five-year projected program. The commission shall also submit any recommendations for legislation with respect to the state health care benefits program.

Sec. 4. K.S.A. 75-6501, 75-6506 and 75-6509 are hereby repealed.

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

except as provided (d)(6) of this section, the rate

at least

rate

(5) the entity shall elect to participate for a minimum of three consecutive years in the state health care benefits program.

(6) the commission may authorize an entity to pay less than the state rate for the employee coverage for no more than three years and no more than five years for dependent coverage on the condition that the entity elects to participate for at least three consecutive years after first paying the state rate for employee coverage

Madame Chair, members of the committee, my name is Ed McKenzie. I am a practicing chiropractor from Holton, KS. I represent the Kansas Chiropractic Association as well as those citizens of Kansas that rely on insurance companies to help pay their medical expenses. I am here to speak in favor of Senate Bill 542.

In a perfect world, regulatory laws would not be a necessity but as we all know, regulation must be done to protect the citizens of Kansas. Within our profession there are laws and regulations. As a chiropractor, I must hold myself to certain standards or be subject to discipline. The decisions I make as a health care provider must be in the best interests of my patients. Senate Bill 542 is a big step toward seeing that insurance companies meet certain standards during their process of reviewing claims.

I have several concerns with the current system:

- People reviewing claims may not be licenced practitioners.
- Licensed reviewers may not be licenced in the state of Kansas and may not be familiar with the laws and regulations in our state.
- Reviewers may not be actively engaged in the practice of their licenced discipline.
- Reviewers may be hired or contract with insurance companies based solely on their ability to reduce claims.
- Reviewers need not identify themselves or be called upon to substantiate the outcome of their reviews.

From a personal standpoint, I have seen instances where several claims sent to one insurance company were predictably be reduced. One could take the amount of the claim and in each case find out the allowed amount just by using a percentage of the total to find out the allowable claim amount. Arbitrary reduction without reviewing the merits of the individual claim is detrimental to the patients that then must pay for the difference.

Senate Bill 542 would make several changes in the claims review process to help protect patients seeking health care. Requiring a reviewer to derive a majority of his income from his active practice makes that person be subject to the same rules he/she uses to review claims. Requiring the reviewer to be licenced in the state of Kansas means that he/she should be familiar with the laws of Kansas.

I have served on peer review committees that reviewed claims that had been cut by professional reviewers and realize that those professional reviewers have no one to answer to except the company paying their fee.

Madame Chair and members of this committee, I respectfully request that you support passage of Senate Bill 542. Thank you.

Edward D. McKenzie, D.C.

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Testimony SB 542

Chairperson Praeger and Members of the Committee:

Introduction:
Dr. Timothy D. Bolz, DC Practicing Chiropractic Physician Topeka KS for 16 years. Chairman or co-chariman Kansas Chiropractic Association's Peer Review Committee 12 years. Serving on the Kansas Worker's Compensation Medical Fee Advisory Panel as co-chairman since its inception in 1989.

K.S.A. 40-22a04 is a statute designed to protect the citizens of Kansas from unscrupulous reviews that affect the quality of health care provided in this state. However, further steps need to be taken to guarantee citizens of this state are treated fairly in the process reviewing the medical necessity of healthcare services and not burdened with additional expenses that were claimed to be covered expenses when healthcare coverage was purchased.

Reviews have historically been used to determine the necessity of healthcare given to an individual for illness or injury. A review may be concurrent with treatment or post treatment. A review is usually a paper review of the treating physician's records concerning all aspects of treatment. From this review, it is determined what expenses will be paid regardless of what the patient was told at the time the coverage was purchased. Vague statements in insurance contracts such as all 'medically necessary' services or 'reasonable' services are covered are the loopholes used to deny payment. Currently, reviews affect Kansas insureds in all aspects of insurance from HMO coverage, to individual insurance, to automobile personal injury protection and worker's compensation. Nationally, many cases of denial of necessary services have been uncovered by the press and several lawsuits settled after patients have been denied treatment.

At this time, there is no mechanism to verify if a review person is a licensed physician. Many reviews I have seen are unsigned. In these situations, no one knows if denial of necessity is by a nurse, doctor or a clerk reading from a 'cookbook' written by statisticians that have determined 'average utilization'. The organization paying for the review always refuses to identify the reviewer to 'protect their privacy'. Generally it takes filing of legal action to discover who conducts reviews. Often injured or ill persons end recommended treatment due to the statement of denial of payment due to 'not medically necessary' or 'exceeds expected length/duration of treatment'. In many situations, patients can be at serious health risk due to the patient's reluctance to incur expenses that should be paid by their insurance contract but are denied.

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It is interesting how Physicians are selected for employment in the review process. It appears that insurers approach physicians fairly new to practice that are only minimally successful. Often a doctor is approached about doing a post treatment paper review. The first review offered is often a case of very obvious excessive utilization. These are easy for the physician to justify, as they are curbing real over utilization. As the number of cases increases and the reviewer becomes more dependent on review income, cases of very normal utilization are sent and the lure of extra income that doing reviews offers is often to much to resist. As the review income becomes greater, the reviewing physician finds it more difficult to offer a decision adverse to their employer, the insurance company. There are reviewers that do so many reviews, there would not be enough time in the day to actually treat patients. It is my opinion that if you cannot make a living practicing your profession, you should not be able to be held out as an authority on treatment of Kansans.

Reviews are the equivalent of treating the patient: medical decisions about an individual's health are made but no one is held responsible for any potentially adverse affects to an insured's health. Just as other activities that affect Kansan's healthcare, review activity should be regulated by the Healing Arts Board of this state.

I would like to recommend two additions to this amendment.

1. All reviewers are subject to the provisions of this statute, not just review organizations. An alternate to this wording would be **all** organizations that use reviews be subject to provisions of this statute.
2. The healthcare providers doing reviews must derive 60% of their income from the practice of their profession and provide proof of such income to the Kansas Insurance commissioner's office annually.

Kansas Association of Osteopathic Medicine

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Testimony on Senate Bill 542
Senate Financial Institutions and Insurance Committee
By Charles L. Wheelen
February 20, 2002

Thank you for this opportunity to express our support for the provisions of SB542. This legislation would raise the level of accountability for physicians and other health care professionals who perform utilization review on behalf of insurers.

Those of you who were involved in passage of the Kansas Patient Protection Act and the law creating the opportunity to appeal for external review of health insurance coverage decisions, will recall that those measures were needed to prevent unscrupulous practices by insurers. While those laws and the Insurance Department regulations that emanated from them are invaluable tools, they do not provide recourse to a patient in the event the patient actually suffers injury or harm as a result of an insurance coverage decision. Our Legislature chose not to grant patients the right to sue insurers because of coverage decisions, and this issue has become the principle obstacle to passage of patient protection legislation at the federal level.

Senate Bill 542 would provide a different form of recourse to an injured patient. Because the insurer's utilization reviewer would be licensed in Kansas, the injured patient could file a complaint to the Board of Healing Arts or other licensing agency so that the reviewer could be held to the same standard of care as the physician or other health care professional who recommended the treatment or therapy that was denied by the insurer. And if the reviewer's decision regarding medical necessity was below the applicable standard of care, he or she could be disciplined by the licensing agency.

In this context it is important to remember that the Healing Arts Act and other licensing laws do not require the applicant to reside or practice in Kansas. In fact it is routine for an out-of-state applicant to obtain a license if he or she is already licensed in another state that has licensing standards equal to those of Kansas. This is sometimes referred to as "reciprocity" or "licensure by endorsement." In other words, this would not create an unreasonable burden for the person employed by or under contract with the utilization review organization. It could result in more contracting between out-of-state insurers and in-state utilization review organizations.

Another important feature of SB542 is the requirement that the reviewer be actively engaged in practice and that he or she not derive a majority of his or her income from peer review and witness fees. In other words, utilization review organizations would be required to employ reviewers who actually work in a health care profession rather than just review charts all day. This would promote genuine peer review among health care professionals, which in turn would promote fairness to the insured patient.

Thank you for considering our comments. We urge you to recommend SB542 for passage.

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KANSAS BOARD OF HEALING ARTS

BILL GRAVES
Governor

235 S. Topeka Blvd.
Topeka, KS 66603-3068
(785) 296-7413
FAX # (785) 296-0852
(785) 368-7102

TO: Senate Committee on Financial Institutions and Insurance

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 20, 2002

RE: **Senate Bill No. 542**

Thank you for the opportunity to appear before you on behalf of the State Board of Healing Arts in support of Senate Bill No. 542. Very simply, this bill would require that the conduct of both prospective and retrospective utilization review of health care services provided by Kansas health care providers on Kansas citizens be performed by providers who are licensed and actively practicing in Kansas.

For many years, even prior to the enactment of the Utilization Review Organization Act by the 1993 Legislature, the Board has been of the opinion that determinations of necessity and appropriateness of health care services constitute the practice of the healing arts in the state of Kansas. Following the enactment of the Utilization Review Organization Act, I attended the meetings of the Utilization Review Task Force which developed the current rules and regulations and urged that clinical peer reviewers who conduct reviews be licensed in this state. However, K.A.R. 40-4-42e was promulgated and requires merely that providers hold a nonrestricted license in a state of the United States. Therefore, under current law, providers licensed in New York, California or any other state are allowed to determine the necessity and appropriateness of treatment provided by Kansas providers on Kansas citizens.

In its Principles of Medical Review, the American Medical Association states:

> "Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service, and should be professionally and individually accountable for his or her decisions."

In May 1998, the House of Delegates of the Federation of State Medical Boards of the United States, Inc. adopted a report by the Special Committee on Managed Care which states, in part:

> "....Because medical directors and other MCO employees apply medical judgment in determining if a proposed treatment is necessary, the committee agreed that the determination of medical necessity is in fact the practice of medicine. The committee determined that MCO employees who evaluate and determine a patient's need for medical treatment should be licensed physicians accountable to the medical board in the jurisdiction in which the health plan enrollee resides...."

According to a Legislative Services Report compiled and published by the Federation of State Medical Boards in March 2001, seventeen states require through statute or board rule that medical directors be physicians licensed in the state in which the plan operates. Another Legislative Services Report distributed February 15, 2002, states that bills pending in Illinois (SB1491), Minnesota (HB 28, HB 1209, HB 1210, SB 491), South Carolina (HB 3772), Tennessee (HB 118-HB 122, SB 668-SB 672), Maryland (SB 42) and Vermont (HB 501) would require medical directors of various managed care entities or utilization review programs to be licensed in their respective states.

In conclusion, the State Board of Healing Arts has long believed that health care in this state should be provided by a doctor-directed health care team. Determinations of medical necessity or the appropriateness of proposed treatment constitute the practice of the healing arts. Any such determinations should be made by individuals who are licensed to practice in this state and, therefore, are professionally accountable in this state for their actions.

Thank you for allowing me to appear before you in support of Senate Bill No. 542. I would be happy to respond to any questions.

KANSAS MEDICAL SOCIETY
KMS

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TO: Senate Committee on Financial Institutions and Insurance

FROM: Chris Collins Chris Collins
Director of Government Affairs

DATE: February 20, 2002

RE: SB 542: Utilization Review

Ladies and Gentlemen of the Committee:

Thank you for the opportunity to voice the Kansas Medical Society's support of SB 542.

The Kansas Medical Society supports the central concept articulated in SB 542. Utilization review, as the committee is well aware, is the process used by insurance companies to determine whether health care services rendered by health care professionals were necessary and appropriate and warrant reimbursement under the company's policies. Historically, it has been a source of some frustration for some health care professionals that their clinical decisions have been reviewed, and sometimes reimbursement has been declined, by utilization reviewers who do not share the same education, background or training. Quite simply, utilization review requires the exercise of medical judgement and different branches of the healing arts apply some very fundamental philosophical differences in their approaches to treatment. These differences in education and/or philosophy can be an impediment to understanding why a clinician elected a particular course of treatment. The Kansas Medical Society has traditionally supported the concept that only similarly educated and trained health care professionals should review their peers' clinical judgement. This results in better quality utilization review and expedites the payment process of those claims that should legitimately be paid. However, for obvious and practical reasons, KMS does not support the concept that a similarly educated professional needs to conduct medical necessity determinations on all claims presented for payment.

For the foregoing reasons, KMS urges the passage of SB 542. Thank you for the opportunity to testify today. I am pleased to answer any questions the committee may have.

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Polsinelli | Shalton | Welte

A Professional Corporation

Memorandum

TO: HONORABLE SANDY PRAEGER, CHAIRPERSON
SENATE FINANCIAL INSTITUTIONS AND INSURANCE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL

HEALTH INSURANCE OF AMERICA ASSOCIATION

RE: SENATE BILL 542

DATE: FEBRUARY 19, 2002

Madame Chair and members of the committee, my name is Bill Sneed and I represent the Health Insurance Association of America ("HIAA"). The HIAA is the nations most prominent trade association representing the private commercial health care insurance system. Its 290 members provide health, long-term care, disability, dental and supplemental coverage to more that 123 million Americans. HIAA appreciates the opportunity to submit this testimony in regards to Senate Bill 542. Based upon our review of SB 542, we urge the committee not to act on this bill. The HIAA was one of the major players in 1994, when the utilization review statutes were created. This process was a carefully balanced negotiation between all interested parties in an attempt to craft a utilization review set of statutes that provided the necessary state oversight but at the same time allowing entities to review health care costs to ascertain the necessity, appropriateness and efficiency of any particular health care service, procedure or facility.

The proposed amendments found on page 1, lines 42 and 43, and page 2, lines 1-5, were issues discussed in 1994 when the utilization statutes were being crafted. We stated then and we

reiterate again, that such an amendment will adversely impair the ability to provide utilization review and will disrupt the balance that was struck in 1994.

Simply stated, there is no empirical evidence that Kansas licensees should be the only ones in the country capable of making determinations within a utilization review. If that were the case, entities like the Mayo Clinic and John Hopkins could never be allowed any type of utilization review in the State of Kansas.

We understand the concerns that some individuals raise regarding someone in a far off country making a medical decision affecting a Kansas resident. That was considered and taken care of in K.S.A. 40-22a-04b(3)and (4). The advisory committee that is under the direction of the Commissioner of Insurance can and has provided information to the Commissioner of Insurance, relative to alleged inappropriate utilization review tactics taken.

Thus, based upon the foregoing, we believe that the amendment proposed in SB 542 is inappropriate and unnecessary. Further, we believe that such an amendment will only damaged an appropriate mechanism that is utilized in an effort to effectively keep health care costs down and thus, insurance premiums affordable. With that we request that the committee not act favorably on SB 542.

We appreciate the opportunity to testify and will be happy to answer questions.

Respectfully submitted,

William W. Sneed

WWS:pmk

Kansas Association of Health Plans

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Testimony before the
Senate Financial Institutions and Insurance Committee
Hearings on SB 542
February 20, 2002

Madam Chair and members of the Committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and others who support managed care. KAHP members serve all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid HMO's and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on Senate Bill 542.

SB 542 raises a few concerns with the members of the KAHP. We question whether this bill would require that an initial review of a claim be performed by a provider licensed in the state of Kansas in the practice under review and also actively engaged in the practice of that licensed profession. The internal initial screen by a health plan is generally performed by the plan's internal medical director who may or may not be licensed in Kansas, may not be actively engaged in the profession under review and is not licensed in all specialities. It is possible that the provisions of KSA 40-22a05(e) may address this concern, but we would like the opportunity to clarify this issue with the proponents.

The second matter we would like clarified concerns whether this bill requires a utilization review of a pediatrician to be performed by a pediatrician and a cardiologist be reviewed by a cardiologist? Or does it require that a medical doctor review another medical doctor and a chiropractor review a chiropractor?

Currently, under KSA 40-22a06(b)(1)and (2), a utilization review organization is exempt from the provisions of KSA 40-22a04 as long as the utilization review organization is accredited by and adhering to the national utilization review standards approved by the American Accreditation Health Care Commission; or other utilization review organizations as the advisory committee may recommend and the commissioner approves. A health plan that chooses to be

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approved by an accrediting organization should be allowed to follow the utilization procedures approved by the accrediting entity. The current statute has not been amended since 1994 and we request other current accrediting organizations be included in this list such as NCQA, JCAHO and plans meeting Medicare + choice and Medicaid requirements. The Medicaid plans may be exempt from the requirements of this bill under KSA 40-22a05(e), however, we would like to clarify this with the proponents. Cheryl Dillard from Mid America Health will address the issue of accrediting organizations in her testimony immediately following.

In conclusion, the KAHP would appreciate the opportunity to meet with the proponents of this legislation to look at all of the statutes involved in this proposed bill and determine if the parties can come to an agreement on the goals of this legislation. Again thank you for allowing us to appear before you. I'll be happy to try to answer any questions you may have.

MID AMERICA HEALTH

Senate Insurance Committee
Kansas Legislature
February 20, 2002
Senate Bill 542

Madam Chairman and Committee Members;

I am Cheryl Dillard, Vice President of Public Affairs for Mid America Health (formerly HealthNet) in Kansas City. Thank you for the opportunity to speak to you today about SB 542. We have some comments about this legislation that we hope you will consider in your deliberations.

Under K.S.A. 40-22a06, exemptions to compliance with the current law are granted to health plans who have URAC (Utilization Review Accreditation Commission) accreditation or who are federally qualified. This section, written in 1994, should be updated to reflect the current state of operational reviews for health plans. Few if any plans in Kansas have maintained their federal qualification. In the early days of the managed care industry, federal qualification was the "Good Housekeeping Seal of Approval". But the extensive federal requirements made plans too expensive for employers to purchase and plans let their qualification lapse. URAC, newly named the American Accreditation HealthCare Commission, now is just one of several prominent entities that review and vouch for the operational and financial strength of a health plan.

The two entities most frequently used by health plans for accreditation (and recognized by employers) now are NCQA (National Committee for Quality Assurance) and the JCAHO (Joint Commission on the Accreditation of Healthcare Organizations). In addition, the Centers for Medicare and Medicaid Services (formerly HCFA-the HealthCare Financing Administration) has in place a rigorous set of operations, quality and financial standards that must be met by health plans that want to be a Medicare HMO. Plans with any of these accreditations or contracts have met the highest standards established for our industry. We recommend that the K.S.A. 40-22a06, as referenced in SB 542, be updated to reflect the current situation. To continue to name the URAC accreditation as the only path to an exemption is to unfairly disadvantage plans that have chosen a different but equally rigorous path to achieving the highest standards.
Thank your for the opportunity to raise this point. I'd be happy to answer any questions.

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