Approved: March 23, 2004
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairperson Patricia Barbieri-Lightner at 3:30 p.m. on February 17, 2004 in Room 527-S of the Capitol.

All members were present except:
Representative Cindy Neighbor- excused

Committee staff present:
Bill Wolff Legislative Research Department
Ken Wilke, Revisor of Statutes
Renae Hansen, Secretary

Conferees appearing before the committee:
Representative Bonnie Huy
Representative Tom Kline
Gregory Barker, Attorney, Judge, Wichita
William Sneed, The Kansas State Farm Insurance
Tom Whitaker, Kansas Motor Carriers Association
Karen S. Cox, IMA of Kansas, Inc.
Bill Groce, Fiserv Health
Amy Garcia, Registered Nurse, USD #259
Steven P. Smith, Hinkle Elkouri Law Firm LLC
Carole Ochs, Thayer Aerospace
Kelley Dawson, Friends University
Gary Endicott, Leisure Hotel
Kevin Regier, BEREXCO, Inc.
Lou Smith, Wichita Association of Health Underwriters
Larry Magill, Kansas Association of Insurance Agents

Others attending:
Twenty Eight including but not limited to the attached list.

Hearing on:
HB 2722: Automobile insurance; require desplay of proof of insurance.

Proponents:

Representative Bonnie Huy, (Attachment #1), presented testimony in favor of **HB 2722** requiring proof of insurance that is displayed on the vehicle itself.

Questions were asked by Representatives Scott Schwab and Nile Dillmore.

Representative Tom Kline, (Attachment #2), supports **HB 2722** because the current fine structure for lack of insurance is too high. He would rather see a structure such as this that impounds your vehicle until a person can show proof of insurance.

Greg Barker, municipal judge, Wichita, (Attachment #3), testified in favor of **HB 2722** as he drafted the bill. The current fine structure still does not work to get people to insure their vehicles. There are no other laws that when discovered the officer permits the breaking of the law to continue. Impounding the car that is uninsured would remove a vehicle from the road that would not be covered if involved in an accident.

Questions were posed by Representatives Nile Dillmore, Stephanie Sharp, Scott Schwab, Mike Burgess, Jan Scoggins-Waite, and Bob Grant.

Opponents:

Bill Sneed, The Kansas State Farm Insurance, (Attachment #4), in opposition of this bill gave statistics claiming Kansas has about 8 % of the population uninsured ranking about 43rd nationwide in uninsured motorist statistics, making it very low in non-insured drivers nationwide. Additionally, it was noted that families with 2-3 vehicles would have a difficult time paying 3 months worth of insurance at one time to comply with the 3 month sticker regulation attached to the bill.

Questions were asked by Representative Nile Dillmore about the costs of implementing this bill and for State Farm the estimate was about $4 million dollars.

Tom Whitaker, Kansas Motor Carriers Association, (Attachment #5), is especially not in favor of one section of the bill that allows the commissioner to establish maximum rates for towing and recovery service. Federal law preempts states from regulating rates, routes or service passed in 1994 federally and Kansas complied in 1995. If this bill were to advance they respectfully ask those provisions be taken out of the bill.

The fiscal note was presented.

Hearing closed on **HB 2722.**

Hearing on:

HB 2689: Health insurance; required disclosures to policy holders for group health insurance.

Proponents:

Karen S. Cox, IMA of Kansas, Inc. (Attachment #6), presented testimony in favor of **HB 2689** that told of her companies inability to make sound decisions on quote estimates to prospective clients because they are unable to acquire adequate information on the large claimant insured individuals which tend to bring up the overall estimate of a groups quote. This bill would allow them to make more informed economical estimates for their clients.

Questions were posed by Representatives David Huff, Stephanie Sharp, Patricia Barbieri-Lightner, Scott Schwab, and Bob Grant.

Bill Gross, Fiserv Health-Kansas, (Attachment #7), stating that accurate and appropriate claim and enrollment information is the heart of health benefit plan design and pricing gave reasons why some of the basic claimant information needed to be released in order to make informed decisions on cost of group insurance.

Question were asked by Representatives Ray Cox, Nile Dillmore, Scott Schwab, Bob Grant, and Mario Goico.

Amy Garcia, USD #259, (Attachment #8), spent time briefing legislators on the specifics of being able to lower the cost of insuring employees based on attaining specific knowledge of certain aggregate data. She state that it is critical that they manage their insurance programs as effectively as possible - monies not spent on claims can go to teacher salaries, books and school district programs that leave no child behind. As a school district they have a fiduciary responsibility to taxpayers to know why and where the money goes.

Questions were posed by Representatives David Huff, Scott Schwab, Eber Phelps, and Revisor Ken Wilke.

Steve Smith, Hinkle Elkouri Law Firm L.L.C., (Attachment # 9), presented testimony showing why the HIPAA regulations in effect do not prevent insurance companies from sharing detailed claims information

with employers that are providing group health insurance to their employees. Businesses have to be able to attain appropriate information on their employees in order to be able to acquire the most cost effective insurance for their business.

Questions were posed by Representatives Scott Schwab, Nile Dillmore, Bob Grant, and Nancy Kirk.

Carol Ochs, Thayer Aerospace, (Attachment #10), believes that there is an impropriety of carriers taking advantage of their clients and hiding behind ambiguous verbiage as stated in HIPAA regulations. Without claim information Thayer Aerospace cannot effectively manage their healthcare dollars, or competitively market the company to other carriers of insurance.

Kelly Dawson, Friends University, (Attachment #11), presented testimony with detailed correspondence showing how Blue Cross and Blue Shield denied Friends University access to the information that would enable the University to provide health care coverage to their employees at reasonable costs.

Questions were asked by Representatives Nile Dillmore, Patricia Barbieri-Lightner, Bob Grant, and Jan Scoggins-Waite.

Gary Endicott, Chief Financial Officer, Leisure Hotel, (Attachment #12), gave background of the Leisure Hotel Corporation (Leisure) being unable to obtain necessary information from their insurance companies to aid them in the process of educating employees in ways of keeping costs down. This inability to obtain information safely and anonymously through the insurance company has resulted in Leisure having to obtain detailed medical questionnaires from their employees on a yearly basis. This is highly disruptive to business operations and puts employee health information at risk of getting into the hands of those outside the "need-to-know" process due to the business being in multiple locations around the state. **HB 2689** would help them obtain the needed information to make sound insurance cost saving decisions anonymously.

Questions were asked by Representative Nile Dillmore.

Kevin Regier, Assistant Controller, BEREXCO, Inc., (Attachment #13), stated that the information this bill is trying to make available to them is vital to their business as they try to control and manage their Insurance costs.

Lou Smith, Wichita Association of Health Underwriters, (Attachment #14), the lack of availability of information to employers trying to make important cost savings decisions for their employee benefit insurance packages has caused some employers to make difficult decisions to drop insurance plans as part of their employee benefits. This further drives the number of Kansas citizens without health insurance up. Claim data **HB 2689** provides for can be very important to an employer or his broker to analyze and make recommendations of possible plan changes to mitigate rising costs.

Larry Magill, Kansas Association of Insurance Agents, (Attachment #15), stated that with **HB 2689** the legislature has the opportunity to say to the group health insurance markets in Kansas, beginning with Blue Cross but including all of them, that they must provide enough information to the business so that it can shop the market for the best proposal available in terms of cost, coverage and service. If **HB 2689** is not passed the legislature is saying to the insurance companies that it is ok to withhold vital clam information and, in effect, hold them hostage to whatever the current carrier wants to charge.

Questions were posed by Representative Nile Dillmore.

Fiscal note for **HB 2689** was presented.

Opponents will be heard on February 19, 2004.

Meeting Adjourned.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: February 17, 2004

NAME	REPRESENTING
GREG BARKER	H.B. 2727
Cheryl Dillard	Coventry Health Care
Lon Smith	Fiserv Hlth of Kansas
Bill Grace	Fiserv Health - Kansas
Kevin Regier	Berexco, Inc. HB 2689
Amy Garcia	Wichita Public Schools
Tom Whitaker	KS Motor Carriers Assn.
Bill SWEED	State Farm
Steve Montgomery	United Health Care
Bill Tracy	United Healthcare
Peggy Godwin	Blue Cross Blue Shield KC
Robin Wonhower	KAHP
John Campbell	KID
Carole Ochs	Thayer Aerospace
Kelley Dawson	Friends University
Steven P Smith	Hinkle Elkouri Law Firm LLC
LARRY MAGILL	KAIA
Karen Cox	IMA of Kansas
Gary ENDICOTT	Leisure Hotel Corporation & Kansas Childrens Service League
Susan Schultz	IMA

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: February 17, 2004

NAME	REPRESENTING
Megan Dunn	Hein Law Firm
David Hanson	Ks Insurance Assns

STATE OF KANSAS

Bonnie Huy
Representative, 87th District
Capitol Building, Room 110-S
Topeka, Kansas 66612
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Committee Assignments
Chairman: • Special Claims Against the State
Member: • Ethics and Elections
• Local Government
• Utilities
• Federal and State

HOUSE OF REPRESENTATIVES
87TH DISTRICT

February 17, 2004

Testimony in Support of House Bill 2722
"Uninsured Motorists"

Madam Chair and Members of the Committee, I appreciate the opportunity to testify in support of House Bill 2722, concerning motor vehicle insurance and the requirement to display proof of financial responsibility.

I'd ask how many of you have experienced damage or injury from a collision with an uninsured motorist who was at fault or know someone who has had that unfortunate experience? If so, the bad news is that almost all of those offenders just keep on driving without liability insurance coverage.

My grandson was recently sideswiped by a pickup truck owned by an uninsured motorist. The damage exceeded $1,000 and he doesn't have $1,000 for the necessary repairs. He had to have his car towed at his own expense; he was without a vehicle for three weeks until he could afford to replace a tire and a wheel. I'm sure the offender still has his pickup which was not damaged and that he is still driving on Kansas roads.

Current legislation gives motorists without insurance six months in jail and fines of $300-$1000 for first offenses. Second offenses result in one year in jail and an $800-$2500 fine. Punishing the offender with these heavy penalties is costly and I'm told is not effective because the offender rarely pays off the fines and keeps on driving. Approximately 100,000 citations are still being issued annually statewide for this offense. Kansas courts are being flooded with cases, resulting in unnecessary judicial expenses borne by the taxpayers. HB 2722 would reduce governmental expense by keeping this issue out of court.

Home Address: 1142 S. Governeour Ct. - Wichita, Kansas 67207 - (316) 685-7958

House Insurance
Date: 2/17/04
Attachment # 1

No[illegible]irance is one of the very few crimes for which law enforcement does no[illegible]p the offense in progress. The officer issues a citation and has to allow the offender to drive on to continue to commit the same offense and to continue to endanger others. Uninsured motorists should not be allowed to proceed on down the road.

The current system forces the "responsible" to also be responsible for the "irresponsible" by having to pay higher rates due to the number of uninsured motorists on the roads.

HB 2722 would require that proof of financial security for motor vehicles registered in this state be prominently displayed on the license plate or in the rear window of the vehicle. If proof of current liability insurance is not visibly displayed, law enforcement would impound the vehicle. This legislation would reduce congestion in the courts, force drivers to obtain and display proof of insurance or risk towing and impoundment costs, resulting in lower costs for insured drivers and Kansas taxpayers.

In my view the cost outlay of owning a vehicle includes not only the purchase price of the vehicle, but also the cost to obtain the license plate, a driver's license and liability insurance coverage. If a citizen cannot afford all the associated costs of owning a vehicle, he or she should not be afforded the privilege of driving and endangering the property and lives of law-abiding citizens who do carry the mandatory liability insurance.

We are not plowing new ground with this legislation as Ohio and Louisiana have impoundment provisions in their insurance laws that provide for mandatory periods of impoundment, in addition to fines, jail and administrative fees whereas HB 2722 would only impound a vehicle until evidence of insurance is produced and storage and tow charges are paid.

Thank you and I'll stand for questions.

Representative Bonnie Huy
District 87

STATE OF KANSAS

THOMAS M. KLEIN
REPRESENTATIVE, 103RD DISTRICT
SEDGWICK COUNTY
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TOPEKA

HOUSE OF
REPRESENTATIVES

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TAX, TRANSPORTATION &
JUDICIAL BUDGET COMMITTEE

Testimony on H B 2722

By Rep. Tom Klein

House Committee on Insurance

February 17, 2004

House Bill 2722 requires that proof of insurance be displayed on the vehicle or license plate. I Support this idea because the fine structure on page 4 lines 31-38 are too high. It is my experience that this fine structure often causes lower income people to choose between insurance and paying the fine when it should be the states goal to see that all drivers are insured.

In its current form, the bill contains both the fine provisions and the display of insurance and impound provisions. I would prefer if the bill were amended so that both sections only applied in those cases where there is an accident or some kind of property damage.

I would be happy to stand for questions.

Rep Tom Klein
103rd District

House Insurance
Date: 2/17/04
Attachment # 2

GREGORY K. BARKER
1540 North Broadway
Wichita, KS 67214
(316) 263-0783

Insurance Committee
Kansas House of Representatives
Capitol Building
300 SW 10th St.
Topeka, Kansas 66612

SUBJECT: Testimony in support of H.B. 2722; regarding K.S.A. 40-3104(g) Motor Vehicle Liability Insurance Coverage Required; ...Penalties for Failure to Maintain Financial Security;...

MY BACKGROUND: I am a lifelong Kansas resident, and have been a licensed Kansas attorney for 24 years. During that time, I have served as a city attorney, assistant county attorney (Geary Co.), defense attorney, and municipal judge (Wichita). I have handled thousands of motor vehicle insurance cases in Kansas courts.

THE PROBLEM: The current penalties for driving without insurance of up to six months in jail and a fine of $300 to $1,000 on the first offense; and up to one year in jail and a fine of $800 to $2,500 on the second offense are not effective. Despite these severe penalties, it is estimated that 20% to 30 percent of the vehicles on our roads are not insured. The heavy mandatory fines make the obtaining of insurance for violators even more difficult, if not impossible. Prosecutors and judges around the State attempt, in good faith, to deal with this difficult situation as best they can, but having the courts deal with what should be an administrative matter results in clogged dockets and unnecessary judicial expense for the taxpayers.

DISCUSSION:

1. We should consider uninsured vehicles as *dangerous instrumentalities*, and not have law enforcement officers simply give them citations and allow them to drive away with court dates weeks into the future. I cannot think of any other criminal offence that law enforcement officers simply allow to continue to be committed when discovered. Rather, they should be immediatly taken off the road, as we would a vehicle with unsafe equipment or an impaired driver, and not allow them to proceed. This is not a radical solution, in Wichita for example, we already tow and impound cars for merely being parked in one place to long.

2. Vehicles should be required to display proof of insurance <u>outside</u> the vehicle as we do park permits and tag registration. After all, what is more important, proof of payment of a $7 park permit or proof of insurance?

3. By getting the uninsured 20% -30% of the drivers to pay, we could lower premiums for everyone else, as the rest of us are in effect paying their premiums through higher rates.

House Insurance
Date: 2/17/04
Attachment # 3

SOLUTION:

1. **Require the display of proof of insurance on the license tag or inside the rear window.**
2. **Vehicles that do not have proof of liability insurance should immediately be towed and impounded, at the owner's expense, until proof of insurance is provided and towing and stowage fees are paid. I can assure you that drivers will "bail" their cars out much quicker than they will pay fines. Let drivers use the fine money for insurance premiums. Jail the car, not the person!**
3. **Save the criminal penalties under this statue for use in conjunction with repeat offenders or for special cases such as DUI or Hit and Run.**

Sincerely Yours;

Greg Barker

Polsinelli | Shalton | Welte

A Professional Corporation

Memorandum

TO: THE HONORABLE PATRICIA BARBIERI-LIGHTNER, CHAIR
HOUSE INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
THE STATE FARM INSURANCE COMPANIES

RE: H.B. 2722

DATE: FEBRUARY 17, 2004

Madam Chair, Members of the Committee: My name is Bill Sneed and I represent the State Farm Insurance Companies ("State Farm"). State Farm is the largest insurer of automobiles in the United States and Kansas. We appreciate the opportunity to testify on H.B. 2722. H.B. 2722 amends current law to require that proof of financial security will be displayed on the window and/or the license plate of the motor vehicle. Although we applaud the forward thinking of the authors of this bill, we must regrettably oppose this proposal.

Our reading of the bill indicates that the law would require the window sticker/license plate sticker be provided every ninety days. That means that every ninety days the insurer would either have to print or mail a sticker, or provide proof to the Department of Motor Vehicles of insurance. Due to the short time period, this would have to be done electronically. My client has been voluntarily working with the DMV on electronic information. However, this mandatory program would cause an enormous expense, and quite candidly, we are uncertain as to whether the software and hardware are even available to support such a program.

My client's system is not keyed to printing window stickers, and presumably we would have to purchase equipment capable of such a function, if one exists. We would also have to reprogram our computers to trigger verifications of insurance every ninety days. This would be an incredibly expensive and time-intensive process.

We recognize that uninsured motorists are a problem throughout the country. However, it is important to remember that the most recent research indicates that only 8% of all accidents in Kansas involve an uninsured motorist. Kansas ranks 43rd of the 50 states. The proposed response is disproportionate to the exposure. Although we have no real way of gauging the total cost, our IT department indicates that an initial cost of starting such a program would be in excess of four million dollars, and that would only cover the State of Kansas.

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House Insurance
Date: 2/17/04
Attachment # 4

Further, there is no direct tie between our company and other insurance companies throughout the state. Thus, we could end up with a mixed bag of results between the various companies.

There are additional concerns relative to individuals who pay on a monthly basis. There are people who fail to pay, and then are later reinstated. The potential costs on an ongoing basis seem to be enormous.

Thus, we respectfully request that the Committee take no action on this bill, as we do not believe it would be in the best interest of the insuring public.

I would be happy to discuss this at your convenience.

Respectfully submitted,

William W. Sneed

William W. Sneed

WWS:kjb

KANSAS MOTOR CARRIERS ASSOCIATION

P.O. Box 1673 ■ Topeka, Kansas 66601-1673 ■ 2900 S. Topeka Blvd. ■ Topeka, Kansas 66611-2121
Telephone: (785) 267-1641 ■ FAX: (785) 266-6551 ■ www.kmca.org

Trucking Solutions Since 1936

LEGISLATIVE TESTIMONY
by the
Kansas Motor Carriers Association

Presented before the
House Committee on Insurance
Rep. Patricia Barbieri-Lightner, Chairman
Tuesday, February 17, 2004

MADAM CHAIRMAN AND MEMBERS OF THE HOUSE COMMITTEE ON INSURANCE:

I am Tom Whitaker, executive director of the Kansas Motor Carriers Association representing our more than 1,200 member companies and specifically our 78 towing and recovery companies. I appear here this afternoon in opposition to House Bill No. 2722.

Our opposition rests with the language found on Page 2, lines 32 through 37 of HB 2722. This provision reads: "The commissioner is authorized to establish and publish maximum rates for towing and storage for vehicles impounded pursuant to this subsection. Any lien upon a vehicle for towing and towing charges incurred as a result of a law enforcement ordered impounded under this section shall be subordinate to any lien of record previously filed with the division of vehicles."

The State of Kansas is prohibited from establishing rates for intrastate transportation of property, except household goods and passengers. 1994, Congress passed the Federal Aviation Administration Authorization Act. The FAAAA preempts state laws "related to price, routes or service" of any motor carrier with respect to transportation of property.

Further, under the provisions of K.S.A. 8-1103, towing and recovery companies have a first and prior lien on a vehicle when the tow is ordered by law enforcement or the owner. The provisions of HB 2722 conflict with current law.

Based on these concerns, KMCA opposes HB 2722 and asks that the Committee report the bill unfavorably. We thank you for the opportunity to appear and would be pleased to respond to any questions you may have.

House Insurance
Date: 2/17/04
Attachment # 5

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AFFILIATIONS: Assurex, Intersure

Testimony by Karen S. Cox
IMA of Kansas, Inc.
House Bill No. 2689
House Insurance Committee Hearing
February 17, 2004

Madam Chair and the House Insurance Committee, thank you for allowing me to appear in front of you today to testify in support of HB 2689.

My name is Karen Cox and I am Vice President of the Employee Benefits Division at IMA of Kansas, Inc. IMA is the largest independent insurance agency and brokerage in Kansas, the 43rd largest broker and the 19th largest privately owned insurance agency in the U.S. IMA provides brokerage and consulting services for approximately 200 employers in Kansas and surrounding states ranging in size from 25 to 2000 employees. I, personally, have worked in the insurance industry for 26 years and currently specialize in consulting with employers on plan design, funding alternatives, claims management and health and wellness initiatives. I am here today because I am concerned about the direction the health insurance industry has taken and the inability to acquire the necessary tools to negotiate the lowest possible insurance costs to ultimately keep health care affordable.

Health care costs have experienced double-digit increases for the past 5 years. That trend is expected to continue and at the current rate of 12.7%, the projected increase for 2004, health care premiums will nearly double in 5 years. In Kansas, we have experienced increases ranging from 20 to 40%. Our employer clients have said they cannot take another round of increases like this. Some are approaching the point of seriously considering whether or not they can continue to provide their employees with health insurance. Their revenues aren't increasing at this rate and employees' wages are not going up enough to make up for their increased costs. With each rate increase, more employees are simply dropping out of the group plan, increasing the number of uninsured.

Short-term solutions of increasing deductibles, copays and out-of-pocket maximums are only band-aid fixes. They do not get to the root of the problem. Employers need to manage their risks and costs carefully. To do so, they need the tools to help them and the first step is detailed claims utilization data.

Just as we're looking to employees to take more responsibility for their health care through consumerism, the same approach is true of employers. We can't expect health care providers to reduce costs by giving deeper discounts; we can no longer expect physicians to control the utilization of health care through pure managed care and we can't control the supply of services. We can't fix health care costs but we certainly start managing them. Employers must take the responsibility of managing their own costs. Health insurance premiums should not be any different than any other business expense. There is no other business expense of this magnitude that employers don't carefully

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monitor or hold someone accountable. It's just good business sense to do the same for their health insurance.

Just as employees need the tools to be better consumers, employers need the tools to be better purchasers of health care. Employees are now getting access to websites providing detailed information on medical conditions, self-help and home remedies, generic alternatives to brand name prescription drugs, and quality and cost information on providers. They also can have immediate access to their claims utilization with calculators to assist them in evaluating benefit options based on their own individual needs. They also have a wealth of wellness tools available, including access to "health coaches" to assist them in managing their chronic illnesses.

It should be no different for employers. They need to know how and where their health care dollars have been spent. They should receive a detailed accounting of what their expenses have been and be able to adequately assess and manage their risk.

Because there is such an inconsistency in carrier reporting to employers, it has become increasingly difficult, and in some cases, impossible, to negotiate renewal rates and seek competitive bids. In these cases, employers have no other alternative than to somehow absorb the exceptional rate increases or drastically cut benefits.

Insurance is based on predicting the probability of risk. Risk is determined by looking at the past claims experience of a group and projecting it forward with some degree of probability or credibility. Unless a group is purely community-rated, their claims experience is going to drive to some degree their rates. Therefore, they have every reason to carefully monitor their claims experience and costs.

That is why employers need the level of detail we are requesting in House Bill 2689. It is essential that they need to know where their claims experience is coming from and who their large claimants are to enable them to determine the diagnosis, prognosis and current status to ultimately qualify and quantity as much as possible their future risk. Otherwise, they will be paying for risk that isn't there and they can no longer afford to do so. In fact, some carriers require complete disclosure of large claims or they will decline to quote.

To give you an example, I personally had a client of 230 employees who received a 37% increase at their renewal. Their renewal rates were based off of 3-years of claims experience. Also included in the renewal was a report that listed their large claimants for the past 3 years. Because I had the names, I was able to confirm that all of the large claimants were either deceased or no longer employed. I was able to legitimately prove that the risk the existing carrier was rating for was gone and we were able to reduce their renewal premiums by $50,000 or 3.7% without having to change carriers. We can now no longer get the names of the large claimants and therefore, cannot quantify or validate the anticipated risk, therefore, losing any basis for future negotiations. This information used to be provided but some carriers began hiding behind HIPAA as a reason not to provide it any longer. Now that it has been established that HIPAA is not a valid reason

for releasing this information, they simply say "it is a business decision". This is even true on self-funded groups.

Another example is IMA's own employee group. IMA is a group of 183 enrolled contracts. We received a 36% increase effective January 1, 2004. Our group's experience is 45% credible and our actual loss ratio was 115%. However, after estimating claims that were incurred but not reported and after applying trends our projected loss ratio for the renewal period was 164%, thus the 36% rate increase. Unlike years past when we received names in addition to the total claims dollars paid per individual, we only received a list of claims in excess of $25,000 without any additional information like diagnosis or enrollment status of the claimant. This list represented 56% of our total paid claims dollars and one claimant alone represented 24% of our total claims paid. We had no information to determine the validity of these claims or the probability of the continuing risk to enable us to truly analyze our costs and seek competitive bids. The insurance carrier repeatedly denied providing us any additional information, including diagnoses. Our employees pay a portion of the premium and we could not ask them to absorb a 36% increase, nor could we expect the company to. It took us weeks of working with our HR department to try to guess and determine who some of these individuals were to validate the ongoing risk and enable us to get bids. I have to say that without our level of expertise in this industry as consultants, we would have not been able to work through this increase and find cost effective alternatives. Not every employer has this expertise available.

Aside from negotiating renewals and obtaining bids, another way employers can begin to manage their health care costs is to manage their risk. Detailed claims and utilization data is essential to begin this process. Many employers prefer to obtain this information through an electronic data dump, allowing them to run their own reports. Rather than special order reports that usually either cost more because they are a custom report or they can't be provided, employers can virtually slice and dice their data a million different ways, creating their own reports. This enables them to detect their own group's problems with medical utilization or plan cost, isolate the root causes of utilization problems and create solutions that save money.

For example, one group of 184 employees ran this report and discovered that their office visits utilization per 1000 was twice the benchmark, which was based on industry, group size and geographic location. Because they were able to run their own reports, they drilled down and discovered that the majority of office visits were chiropractic related. After further drilling down, they were able to determine that most of the visits were from one provider. Their solution: they couldn't treat that provider differently because they were in the network so they set an appropriate maximum on the number of chiropractic visits per year. Had they not been able to drill down and determine the root cause of their office visit utilization, they would have increased their office visit co-pay which would have affected most all of their employees and maybe even prevented some individuals from going to the doctor when they really needed to. The additional claims utilization allowed them to get to the root of the problem and make a benefit change that would only impact those who had caused the increased utilization.

This information has been provided by BCBS in the past for a cost of $3,000. However, they will no longer provide employers with their own data in this format. It is hard to understand why insurance carriers wouldn't do everything they can to help employers maintain their group health plan by helping them to contain costs. They first said it was because of HIPAA although there is no identifiable data requested in the report. They now say it is proprietary although it is the groups own claim data.

This same report has been provided to 1190 different employer groups from 336 different insurance carriers and administrators across the country. Of those 336 carriers and administrators, 17 of them are Blue Plans.

To preserve health benefits for employees, we must ask for your help in mandating a level playing field in providing Kansas employers the tools to help them negotiate and pay the fairest price possible for their health insurance. The current practice by insurance carriers is stifling competition and crippling employer's efforts to manage one of their largest expenses. Only through sound health care management can we resolve this problem.

To summarize, we used to get detailed claims data, some carriers provided better claims information than others, HIPAA is not a valid reason to withhold detailed claims information and underwriters will continue to require claims detail to accurately access risk and rate a group. If adequate claims information is not available, underwriters will err on the conservative and either quote higher rates or decline to quote.

Employers can't continue to counter sharp rate increases by shifting costs to their employees and/or cutting back on benefits. I personally applaud any employer who wants to take the responsibility to be accountable for his or her own group's risk and be proactive in managing it. It's just sad that employers who want to keep providing good health care benefits to their employees and are willing to take ownership in finding solutions can't because insurance carriers won't help them. Just think were we would be if every employer took that kind of ownership; we wouldn't be here today.

Employer-sponsored health insurance is under stress as never before due to the seemingly unstoppable escalation in the cost of medical care. It is critical that players on all levels come together and address this problem before one of the hallmarks of the American workplace is damaged beyond repair. Now, more than ever, should every party do as much as possible to assure that all Kansans can maintain quality and affordable health care.

Reasons Why You Should Demand Protected Health Information (PHI) From Your Health Plan

The cost of health care continues, for the fifth straight year, to experience double-digit increases. Even though medical trends are estimated between 15% and 17% for 2003, increase in premiums can be as high as 50%. Depending on the size of your group, your claims experience will influence your rates to varying degrees. Therefore, it is in your best interest to closely monitor your claims experience and know what is driving your premiums.

Unfortunately, health insurance carriers have taken the position of withholding this vital information, citing HIPAA as the reason for not being able to provide this to their customers. HIPAA does not "prevent" this information from being released; it merely says that, as a condition of receiving this information, you have to take certain steps, such as agreeing to protect the information if it is received.

There are two principal reasons why an employer and/or its broker might need (or want) to have access to "PHI" from the insurance carrier (or claims administrator) for the employer's group health plan.

1. **To Ensure that Claims Are Being Correctly Processed.**
   The first reason is to make sure that the insurance company is correctly processing claims. Particularly with large claims, it is common for an employer and/or its broker to make sure that the claim is properly payable by the plan. Situations in which a claim might not be payable by the plan include the following:

   - **Coordination of Benefits**. Someone other than the group health plan should have paid the claim. For example, the claim should have been paid under the spouse's plan, through the worker's compensation systems, by Medicare or through the "personal injury protection" benefits under an automobile liability policy.

   - **Person is Not Covered Under the Plan.** The claim is for a person who is not covered under the plan. For example, it may be that the person is no longer part of the group. This could include a person who is no longer employed by the employer and who did not elect COBRA. It could also include a divorced spouse who is still being covered as a dependent (rather than as a COBRA beneficiary) because the employee failed to inform the group health plan of the divorce. Or, it could be a situation in which the person was never part of the group but the claim was posted to the group by mistake.

- **Benefits are Not Payable Under the Plan.** The benefit sought is not a benefit that is provided by the plan. Although one would generally expect an insurance company to know what benefits are payable and what are not, mistakes do sometimes happen. If the employer does not receive detailed information about the claims that have been paid, it is possible that a mistake of this type would never be caught.

2. **To Negotiate Renewal with Existing Carrier and Obtain Bids from Other Insurance Companies.** The second reason an employer and/or its broker might need (or want) PHI is to negotiate the renewal with the existing carrier or obtain bids from other insurance companies when coverage is up for renewal. As a general proposition, rates are based on the actual claims experience of a group. This actual claims experience would be reflected in the "summary health information" for the group, but there may be times when further analysis is warranted. Such situations include the following:

   - **Confirming the Accuracy of the Summary Health Information.** It is possible that the group's "summary health information" contains mistakes. As noted above, for example, the "summary health information" might include claims that were not properly payable under the plan, such as claims that should have been paid by worker's compensation or Medicare, claims for persons not covered under the plan, or claims for benefits that were not payable under the plan. Again, if the employer does not know the name of the person incurring the claim, it is doubtful that this type of mistake could be caught and the employer will be assessed with this cost.

   - **Identifying Non-Recurring Claims.** If a group has incurred large claims in the recent past, the rate that is quoted is likely to be higher than for a comparable group that has not had such claims. If, however, an employer or broker is able to persuade an insurance carrier that the group is healthier than its prior claims experience might indicate, a more favorable rate should be quoted. This could be the case, for example, if a person who incurred a large claim is no longer part of the group. This could be because the person has died or because the covered participant left the group without electing COBRA. Without knowing the names of the persons who have incurred large claims, however, an employer or broker may have a difficult time identifying such claims and calling them to the attention of the current or prospective carrier.

It is a big expense for your company to provide your employees with medical insurance. To enable you to continue to provide these benefits, you need to be able to obtain the necessary information to help you manage this costly operating expense. If you would like additional information on how your claims utilization actually affects your rates or if you would like to know how to acquire this information, please contact your IMA representative.

Actual Case Examples Regarding Use Of PHI in Rating

Example 1:

A group of 207 contracts received a projected increase of 37%. The group was provided three years history of large claimant information, which included name and total claims paid. During the 3-year history, paid claims on large claimants totaled $657,926 of which $573,836 (87%) was on employees who were either terminated or deceased. After notifying the insurance carrier of that information, the group's expected claims were reduced by $43,464, which resulted in a 3% rate reduction. Had we not received PHI on this group, their renewal rates would have been overstated unnecessarily.

Example 2:

A group of 194 contracts received their renewal, receiving a 24% increase. Large claimant information provided at renewal showed the total claims paid, the ICD9 Code and the ICD9 Code Description. Two very large claims were noted, one for $332,424 and another for $248,346. After further requests, we were able to get the status of the claims, which indicated either "ongoing" or "resolved" and the diagnosis. One of the large claims indicated end stage renal failure. After further persistence, we were able to determine the claimant had been on COBRA since 1/1/02 and became eligible for Medicare 8/1/02. The insurance carrier had continued to pay claims after 8/1/02 as primary instead of secondary resulting in an overpayment of $25,000. Identifying this claimant was important for two reasons: we were able to identify an administration error resulting in claims paid in error and charged to the group and we were able to prove that their potential and anticipated risk would be reduced significantly because Medicare was primary AND the individual's COBRA would end 7/1/03.

Example 3:

A group of 63 employees received a 53% increase. Shock listings showed diagnosis and amount paid only. This information included an Acute Lymphoid Leukemia in which claims amounted to $189,000 over the past 7 months. There was also a stomach cancer with $52,000 paid, and another leukemia at $23,000 paid over the last 7 months. There was no PHI information given and the employer had limited knowledge. No information was given as to whether it was on going, closed, or whether the patient was an insured or a dependent.

Based upon the limited amount of information on these conditions, all carriers that IMA sought bids from declined and we were unable to help the client.

Example 4:

A group of 166 contracts, received a 35% increase effective 8/1/03. A large claims summary was provided with the renewal which referenced all claims paid over $10,000 with a diagnosis, total claims paid and a status that indicated either "active/ongoing" or "terminated". A Chronic Renal Failure with $106,365 in claims paid over the last seven months was listed. We had no way to determine who this claim was on to determine where the individual was in their treatment (if they were on a transplant list, how long they had been on dialysis, etc). As a result, all fully insured carriers declined. Most self-funded quotes included contingencies that required disease specific questionnaires on many of the large claims, including the chronic renal failure before final rates could be provided. We couldn't meet these contingencies and provide the additional information because we had no idea who they were.

Wichita Business Journal - February 16, 2004
http://wichita.bizjournals.com/wichita/stories/2004/02/16/story3.html

WICHITA BUSINESS JOURNAL

EXCLUSIVE REPORTS

From the February 13, 2004 print edition

Bill aims to get health insurers to disclose more info to employers

Jerry Siebenmark

A bill before the Kansas Legislature supported by insurance agents and brokers aims to make it easier for companies with 50 or more employees to get the information they need to shop for better health insurance rates and manage their health care costs.

House Bill No. 2689 would require health insurance companies to provide their business customers detailed information -- including in some instances the names of employees and what kinds of medical care they have received.

Some insurers oppose the bill and say they are not about to release specific information about their members to employers.

"I think the strongest thing to iterate here ... is that no one seems to have trouble with what's being made available now," says Graham Bailey, spokesman for Blue Cross Blue Shield of Kansas.

But brokers, agents and at least one employer in the state take exception to Blue Cross' assertion.

Useful information

The city of Hays, Kan., last week terminated its contract with Blue Cross. It did so, in part, because Hays could not get the claims history information it was seeking, and had received in previous years from Blue Cross.

The information the city of Hays was seeking, called "group health loss information," includes monthly premium and claims experience and deductible utilization reports. That data allows employers to discover, for instance, if insured employees are using hospital emergency rooms for illnesses and injuries that aren't life-threatening and could be treated in a doctor's office, which is less costly.

Amy Garcia, risk manager for USD 259, says a company armed with that kind of monthly claims information could then move to educate the employees on when it is appropriate to use an emergency room.

"That tells me I need to do some education and restructuring (of benefits) that makes it a little more costly (for employees) to go to the ER," says Garcia, who adds USD 259 is not affected by the bill because it uses a self-funded plan.

The bill would have compelled Blue Cross to provide the information Hays officials say they needed -- and previously received -- to manage their costs.

Hays city officials say the information is key to shopping for the best rates. A detailed history of how employees have used the city's insurance provides a competing insurer with an accurate assessment of what future use may be. Without that information, employers and insurance agents say, competing insurers will often hedge by bidding higher rates.

"We having nothing against Blue Cross as an insurance company or how it handles claims, but we need the flexibility to select or take bids and that information is key to that bidding process," says Hays city manager Randy Gustafson.

Gustafson also says the city's new insurance carrier, Wichita-based Preferred Health Systems, had a lower bid than Blue Cross.

Supporters of the legislation, which include the Kansas Association of Insurance Agents and the Wichita Association of Health Underwriters, say the bill is not aimed just at Blue Cross.

"I'm pretty confident that it is more than a Blue Cross issue," says Larry Magill, KAIA executive vice president.

A way around HIPAA?

Not all insurers agree with Blue Cross' stance on group health loss information.

PHS, for instance, says it already provides such information to its employer groups.

"It has little effect on our organization from our current business practices," says Brad Clothier, PHS' chief operating officer.

Why the difference in philosophies?

Blue Cross' Bailey says the release of individual-specific information, which the bill requires in instances where claims on an employee exceed $10,000 in a year, violates his company's policy and bypasses the Health Insurance Portability and Accountability Act.

The bill's supporters counter that HIPAA allows access to such information as long as employers have been properly trained.

"(The information) can only be used for the administration of the plan," says insurance broker Gary Hardman, president of Hardman Benefit Plans Inc. "In larger companies many times the owners and officers don't have access to employee information. It's limited to the human resources department so they can properly administer their plan."

Next action on House Bill 2689 is scheduled for 3:30 p.m. on Tuesday, Feb. 17, when the House Insurance Committee will hold a hearing on it. A copy of the bill is available on the Kansas Legislature's Web site, www.kslegislature.org/bills/2004/2689.pdf.

REACH JERRY SIEBENMARK at 266-6192 or on the Web at jsiebenmark@bizjournals.com.

6-10

Hays changing its insurance provider

Nov. 27, 2003

By JEREMY SHAPIRO

Hays Daily News

The city of Hays is changing health-care providers, in part because Blue Cross-Blue Shield did not disclose requested information by the city.

The Hays City Commission voted 5-0 Tuesday to enter into a $955,000 contract with Preferred Health Services for employee health insurance in 2004.

Blue Cross-Blue Shield, the city's insurance provider the past four years, bid was about $7,500 less than Preferred. However, City Manager Randy Gustafson and City Attorney John Bird strongly recommended Preferred.

They said Blue Cross-Blue Shield refused to provide historical group data. The city wanted historical references so they could bid out the insurance, Gustafson said.

Charles Krull, local Blue Cross-Blue Shield representative , said the Health Insurance Portability and Accountability Act, prevented his company from disclosing the information. He said the city wanted names and claims history.

Bird said that was not the case. He said the city never asked for any names. Instead, they asked for claims totals and other financial data. Furthermore, he said Blue Cross-Blue Shield is hiding behind HIPPA rules that don't apply to this situation.

Bird said the prior three years Blue Cross-Blue Shield has willing provided group history information. When the city asked for it this time, they were told no by company attorneys in Topeka, he said.

"We were told they had a change in company policy," he said. "We wanted statistics so other bidders could make intelligent estimates for their bids. This is more an issue of them not wanting competition than HIPPA."

According to Bird and Gustafson, after repeated denied requests, they threatened to file a lawsuit against Blue Cross-Blue Shield. It was then the company provided the statistics at a cost of $100, they said.

Bird put together a document as part of the contract that would ensure the city would be provided similar statistics in the future. Preferred Health Services signed the document. Blue Cross-Blue Shield didn't, Gustafson said.

In response, Krull reiterated they couldn't divulge protected health information. In his opinion, the city was still asking for something they shouldn't be asking for.

Mayor Troy Hickman said regardless of the information disagreement, he thinks Preferred offers better

health insurance coverage. He said a wider variety of prescriptions are covered by Preferred.

In other action:

l Time is ticking on a 2004 animal control contract between the city and the Humane Society of the High Plains.

The city and humane society have not resumed negotiations. The current contract expires Dec. 31.

At the Sept. 25 meeting, commissioners tentatively agreed to a new contract for 2004 pending negotiation of an equitable price. Any agreement must include an 2002 audit.

An accountant is working with the humane society to come up with a cost analysis. Gustafson originally thought the analysis would be complete by mid-November. He isn't pleased with the delay.

Robin Tropper, executive director of the Humane Society, called Gustafson Tuesday to say the analysis will be complete in the next five to 10 business days. Gustafson has set up a meeting with the humane society Wednesday.

"I think the analysis is to classify shelter expenses from animal control expenses," said Dorothy Stites, assistant city manager. "Once we know that, we can better talk about price for the services."

In earlier negotiations the city was offering $92,000, while the humane society was requesting $112,176.

If no agreement is reached before the end of the year, the city will be without an animal control provider and the humane society will be without roughly half of its revenue.

l With minimal discussion the commission passed the Neighborhood Revitalization Plan. The plan offers tax rebates to encourage business owners or homeowners located in the district to make improvements to historic or deteriorated structures. Only the amount of the improvement receives the tax rebate, not the total value of the property.

In the three years the plan has been in effect 20 property owners have invested nearly $2 million in materials and labor for various improvements.

The district boundaries are 14th Street to the north, the city limits to the south, Oak Street to the east and Elm or Park to the west. Also included is a six-block stretch between Oak, Fort, 14th and 17th streets and a two-block stretch between Oak, Allen, Seventh and Eighth streets.

Historical or Properties adjacent to the district might also be considered for rebates.

The Ellis County Commission and USD 489 Hays School Board will also be asked to pass the plan. The school board already passed a plan, but will have to do so again because of changes made by the city commission.

l The commission modified a current ordinance about parking vehicles in front yards. The modification allows residents to park on concrete, asphalt, gravel, brick, sand or rock surfaces in their yards, but not grass. Another modification prevents residents from parking on a grass or vegetative surface in the side of their yards, in addition to the front yard.

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Fiserv Health™

Madam Chair, members of the committee:

Thank you for the opportunity to appear in support of HB 2689. My name is Bill Groce, Group Underwriter, Director of Group Marketing, Fiserv Health – Kansas. I have over 30 years experience in insurance underwriting and work daily with plan design and pricing. I am here to offer support for HB 2689 as vital to the interests of Kansas employers relating to health insurance pricing and benefit plan design.

1. Accurate and appropriate claim and enrollment information is the heart of health benefit plan design and pricing. It is one of the primary measures of performance for an employer's health benefit plan. The lack of availability of appropriate claim information as defined in HB 2689 puts Kansas employers at a disadvantage in managing their employee benefit plans.
2. HB 2689 allows Kansas employers access to claim and enrollment information that is needed for benefit plan design and pricing decisions relating to such things as deductibles, coinsurance, copays and other specific benefits. Without the availability of accurate, appropriate and timely claim information, Kansas employers are not able to intelligently participate in plan design, pricing, or overall plan management decisions at a time when healthcare costs are continuing to rise at double digit rates and endangering the ability of many employers to continue health insurance benefits.
3. Paid health claim and enrollment information as noted in Section 2. (a) of HB 2689 is information needed by Kansas employers and their representatives to review the performance of a health benefit plan and evaluate the expected future costs.
4. The claim and enrollment information detailed in HB 2689 is utilized by health insurance underwriters to project expected costs and set appropriate premium levels. Without accurate timely claim and enrollment data for an employer's plan, premiums may be set unnecessarily high to allow for the "worst" possible outcome. Renewal premiums set by the incumbent carrier may also be artificially high. Claim information relating to individuals with large claims, over $10,000 paid in the prior 24 months, inclusive of the diagnosis, the name(s) of the provider(s) utilized, and the current enrollment status of the individual is the minimum information needed to assist in the projection of future plan claim costs. The key is to be able to make a reasonable appraisal of the future impact of these claims.
5. Informed decisions also require that the information as detailed in HB 2689 be provided on a line by line basis (medical, dental, prescription drugs) to allow pricing and benefit evaluation for each line. Providing aggregated information is of little value.

Respectfully,

Bill Groce

Bill Groce

House Insurance
Date: 2/17/04
Attachment # 7

Support for House Bill No. 2689
Wichita Public Schools, USD 259
February 17, 2004

Madam Chair Barbieri - Lightner, Members of the Committee, it is a pleasure and honor to appear before you in support of HB 2689, which will improve employer access to insurance claim information. I am Amy Garcia, a Registered Nurse, working as the Risk Manager and Benefits Supervisor for the Wichita Public Schools. I am here today to ask for your support of HB 2689, ~~as written~~.

The Wichita Public Schools self funds each of its insurance programs and purchases insurance for the most expensive claims. We currently hire Blue Cross Blue Shield of Kansas to administer our claims, but we assume most of our own risk. The health, dental and pharmacy plan provides care for 6200 benefited employees and their families, at an estimated cost of $40 million. It is critical that we manage our insurance programs as effectively as possible – monies not spent on claims can go to teacher salaries, books and school district programs that leave no child behind. Being self funded, the single most important tool for developing a cost effective plan structure is aggregate information.

Aggregate information about insurance claims has become increasingly difficult to obtain since the implementation of HIPAA. I am a nurse and I do believe HIPAA to be a good and necessary act. The act does provide for disclosure of information, but some insurers have developed overly restrictive agreements that hinder the ability of a business to manage this costly benefit. I think it is sad that HB 2689 is needed, but that is the current reality. I want to present several issues for your consideration:

- Access to aggregate data can allow for wise changes to insurance programs that save money while meeting the needs of a specific population. We will soon launch educational and incentive programs to move 5.3% of our employees from brand name to generic medications. This will save the plan at least $258,042 per year, and will save the employees an additional $76,000. A quarter of a million dollars goes a long ways in these tight economic times. Better access to information will allow us to detect other trends and realize savings. Aggregate information also allows a company to set appropriate deductibles and copays to shape behavior – toward wellness and away from the emergency room.

  Before making any change, a program manager needs to know what impact it will have on the

House Insurance
Date: 2/17/04
Attachment # 8

employee population. I recently requested aggregate information on chiropractic care and wanted to know if the proposed change would impact 100 people or 1000 people? I was told that this was protected health information. First, this type of aggregate data is not protected and second, I am the designated HIPAA officer for the school district. The HIPA Act grants me access to the information I need to advise our union and administrative committees on plan management.

- Wichita Public Schools is an extremely large taxpayer supported entity. We believe that we have a fiduciary obligation to assure the taxpayers that the $33 million allocated to health claims is being spent in the most efficient and effective manner. Currently, we must "trust" that the right amount is being paid to the right person at the right time. During November 2003, our Board of Education approved funds for an outside audit firm to review claims payments. This has not been accomplished, and it might be helpful for you to know BCBS of Kansas reasons for this delay, in successive order:
  1) "We don't do that."
  2) "We will do it, but we will choose 25 files and audit them, and we will let you know."
  3) "You really don't want to spend your money that way."
  4) " Our error rate is only around 2% - and that is normal in the industry."
  5) " We can't do it because of HIPAA."
  6) "We can't do it because you want too much information and our computers can't handle it."
  7) "We can provide the information, but it will cost MANY, MANY thousands of dollars." *After I suggested that we are putting out a Request for Proposals...*
  8) "It will only cost $600, but you will have to sign a confidentiality agreement, because of trade secrets." And so on...
- Blue Cross Blue Shield of Kansas did provide a HIPAA agreement to the Wichita Public Schools that is unduly restrictive regarding access to protected health information. When we inquired, we were told that 99.99% sign it without question. It appears that those who signed off on this agreement, may not have fully appreciated the ramifications. We have countered by offering a HIPAA agreement drawn directly from the model language in the Federal Register – we await resolution on this issue.

My purpose in coming here today was to let you know the difficulties of trying to manage a health plan in the post HIPAA era. I ask you to support HB 2689, which will help employers like USD 259 to spend the people's money wisely. agarcia@usd259.net 316-973-4581

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TESTIMONY ON HOUSE BILL 2689
BEFORE THE HOUSE INSURANCE COMMITTEE
BY STEVEN P. SMITH
HINKLE ELKOURI LAW FIRM L.L.C.
FEBRUARY 17, 2004

Madam Chair, thank you for the opportunity to appear today in support of House Bill 2689. My name is Steven Smith. I am an attorney with the Hinkle Elkouri Law Firm in Wichita, where I practice primarily in the area of employee benefits.

The focus of my testimony is on the HIPAA Medical Privacy Regulations. In particular, I would like to correct the mis-impression that the regulations prevent insurance companies from sharing detailed claims information with employers that are providing group health insurance to their employees.

OVERVIEW OF THE REGULATIONS

The HIPAA Medical Privacy Regulations were issued in final form in December 2000 and were modified in August 2002. 65 Fed. Reg. 82462 - 82829 (Dec. 28, 2000); 67 Fed. Reg. 53182 - 53273 (Aug. 14, 2002). The regulations took effect as to most "covered entities" on April 14, 2003. However, most employer sponsored group health plans were given an extra year – that is, until April 14, 2004 – to comply.

The regulations establish a comprehensive frame work for the protection of information about a person's health. This information is generally referred to as "Protected Health Information" or "PHI."

The basic principle running through the regulations is that PHI may not be used or disclosed *except*:

(1) to provide medical care to a person;

(2) to arrange or pay for a person's medical care;

(3) as required or permitted by certain laws, such as laws relating to the worker's compensation system or "discovery" in civil litigation; or

(4) if the individual has given permission for the information to be used or disclosed in some other way.

House Insurance
Date: 2/17/04
Attachment # 9

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STATED PURPOSE OF THE REGULATIONS

By limiting the use of PHI in this way, the Department of Health and Human Services intended to put a stop to many of the questionable practices that had taken place while continuing to allow the disclosures that are necessary to the proper functioning of our health care system.

The regulators expressed concern that medical records had been accidentally posted on the Internet, that a speculator had attempted to purchase the patient records of a medical practice that had gone out of business, and that drugs companies were obtaining medical information from doctors for the purpose of developing direct mail marketing campaigns. 65 Fed. Reg. at 82467 (December 28, 2000). The regulations have put a stop to these practices.

At the same time, the regulators recognized that individuals benefit when medical information is disclosed in other settings. "Patients also benefit from the disclosure of such information to the health plans that pay for" their care and that health plans need such information in order to evaluate "the quality of that care, and the efficiency with which it is delivered." 65 Fed. Reg. at 82467 (December 28, 2000).

SHARING INFORMATION WITH EMPLOYERS

The regulations expressly allow a number of different disclosures to be made, including disclosures to employers that are sponsoring group health plans if the disclosures are made so that the employer can "carry out plan administration functions" for its group health plan. 45 C.F.R. § 164.504(f)(3)(i).

To get information for this purpose, however, an employer must agree in writing to a number of specific restrictions on how the information will be used and who will be allowed to see the information. This is done by amending the plan document that an employer is required to have under ERISA. Under the regulations, the amendments must:

(1) Establish "the permitted and required uses and disclosures" of PHI by the employer;

(2) Prohibit the employer from using or further disclosing the PHI "other than as permitted under the plan document or as required by law";

(3) Require the employer to ensure that agents or subcontractors to which it provides PHI agree to the same restrictions and conditions that apply to the employer itself with respect to the PHI;

(4) Prohibit the employer from using or disclosing the PHI for employment-related actions or in connection with any other employee benefit plan;

(5) Require the employer to report to the group health plan any use or disclosure of the PHI that is inconsistent with the permitted uses or disclosures;

(6) Require the employer to make PHI available to plan participants, consider their requested amendments to their PHI, and, upon their request, provide them with an accounting of the employer's PHI disclosures;

(7) Require the employer to make its internal practices and records relating to the use and disclosure of PHI received from the group health plan available to HHS upon request;

(8) Require the employer, if feasible, to return or destroy all PHI received from the group health plan if that information is no longer needed for the purpose for which disclosure was made or, if that is not feasible, to limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible;

(9) Ensure that there is "adequate separation" – or, as it is sometimes referred to, a "firewall"– between the group health plan and the employer by:

(a) Describing the employees, class of employees, or other persons under the control of the employer who may be given access to PHI;

(b) Restricting access to and use of PHI by such persons to the "plan administration functions" that the employer performs for the group health plan; and

(c) Providing an "effective mechanism" for resolving "any issues of non-compliance" with the provisions of the plan document by persons having access to the PHI; and

(10) Prohibit the plan from sharing PHI with the employer unless the employer certifies to the plan that the provisions listed above have been adopted and that the employer agrees to comply with those provisions.

45 C.F.R. § 164.504(f)(2). It is noteworthy that these requirements are essentially a mirror image of the requirements that a covered entity, such as a healthcare provider or insurance company, are subject to.

The bottom line is that the federal government has determined that an employer may receive PHI from the insurance company for its group health plan as long as the employer is willing to obligate itself, in a legally binding way, to take care of the information it receives and not to use that information for any purpose other than providing benefits to its employees.

POSITIONS TAKEN BY OTHER PERSONS

This is not a minority view. Representatives of Blue Cross Blue Shield of Kansas, the largest health insurance company in the state, have advised us on multiple occasions that their decision to withhold detailed claims information from employers is unrelated to HIPAA. Commissioner Praeger has said that, in her view, HIPAA does not "prevent" insurance companies from sharing claims information with employers. In her words:

> We agree that the HIPAA Medical Privacy law does not 'prevent' a health insurer from sharing certain information with an employer plan sponsor. Within the framework of the federal medical privacy act, insurance companies can provide, with some limitations, more than aggregate claims information.

Letter from Commissioner Sandy Praeger to Buz Lukens dated May 21, 2003.

In an article analyzing the controversy over the sharing of claims information with employers, the Bureau of National Affairs ("BNA"), a leading publisher of tax and benefits materials, reported that "HHS's position on the issue is clear." It quoted Rick Campanelli, the Director of the HHS Office of Civil Rights, which is responsible for enforcing the regulations, as saying that, if an employer wishes to use PHI for the renewal or replacement of its insurance coverage, it can amend plan documents to provide specific protections and describe how the information can be used for health care operations purposes. If an employer does this, then employer is permitted to use the information for rating, underwriting, creation, renewal, or negotiating a health insurance contract because those functions fall under the umbrella of health care operations. BNA Pension & Benefits Reporter, Vol. 30, No. 34, "Health Insurers City HIPAA in Denying Employers Specific Claims Information (September 2, 2003), at page 1931.

Not every employer will want to assume the burden of taking care of this information, but many will. And under the regulations, it is their choice. Under the regulations, whether they receive PHI from the insurance company for their group health plan is a decision that is up to them.

Many of our clients agree with the view that the Commissioner expressed when she wrote:

> I totally agree with your comments that the exchange of information would be of benefit to policyholders in the administration of their group health insurance plan. As you pointed our in your letter, by increasing access to medical claim information, we allow insurance companies to provide affordable health care to their employees in Kansas. ... Hopefully, it this issue is discussed by the next session of our legislature it will be given serious consideration.

Letter from Commissioner Sandy Praeger to Buz Lukens dated May 21, 2003.

I appreciate the opportunity to appear before this committee today. If the committee has any questions regarding the application of the HIPAA Medical Privacy Regulations to Employers, I would be happy to address those questions at the committee's convenience.

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REPORTER

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HIGHLIGHTS

IRS Extends Deadline for Preapproved Plan Determination Applications
The Internal Revenue Service in Revenue Procedure 2003-72 extends until Jan. 31, 2004, the deadline for certain preapproved pension plans to apply for determination letters that provide assurance from IRS that they remain qualified. The extension applies only to preapproved plans whose GUST remedial amendment period–the period during which plans must apply for assurance that they remain qualified in light of a series of laws enacted since 1994—ends between Sept. 30, 2003 and Jan. 1, 2004. **Page 1897**

Cumulative Decreases in Pension Funding Remain Despite Recent Increases
The funded levels of benchmark company pension plans in most countries, including the United States, increased during the second quarter of 2003, according to the consulting firm Towers Perrin. Despite these gains, benchmark plans in Australia, Canada, the Euro-zone, Japan, the United Kingdom, and the United States, register decreases of between 27 percent and 44 percent in funded status since Jan. 1, 2000. **Page 1899**

Grassley Withdraws Staff Aides From Prescription Drug Conference
Further complicating passage of Medicare prescription drug legislation, Senate Finance Committee Chairman Charles E. Grassley (R-Iowa) withdraws his staff from the ongoing staff-level conference committee meetings to protest conferees' lack of attention to rural provisions. **Page 1912**

Class Action Status Denied in Claim Alleging Promise of Best Benefits
A lawsuit by employees at a Commonwealth Edison Co. facility alleging the company breached its fiduciary duties by promising that employees at that facility would receive a better early retirement package than employees at other facilities is denied class certification by the U.S. District Court for the Central District of Illinois. **Page 1919**

IRS Final Rules Require Stock Option Costs Be Taken Into Account
The Internal Revenue Service refuses to back down from the agency's much-criticized position that compensatory stock options must be taken into account in determining the costs of developing intangibles under qualified cost-sharing arrangements in issuing final regulations on the topic. **Page 1898**

Settlement Agreement Did Not Create Vested Right to Benefits
A settlement agreement between an employer and a former employee that required the employer to "enroll and accept" the employee in its long-term disability benefit plan did not provide the employee with a vested right to benefits, the Kentucky Supreme Court rules. Reversing a lower state court, the Kentucky high court finds that because the settlement agreement did not give the employee a vested right to benefits the employer did not violate ERISA when it transferred the employee to a successor's plan. **Page 1919**

ANALYSIS

CASH BALANCE PLANS: Many believe that the viability of cash balance plans are in jeopardy following a federal court ruling that such plans inherently discriminate against older workers. **Page 1926**

HIPAA: Controvery concerning tighter requirements over the sharing of information between health insurers, fully insured employers, and their brokers—one of many aspects of HIPAA privacy regulations that is causing confusion—is explored in a feature article. **Page 1930**

SPECIAL REPORT

HEALTH INSURANCE: In desperation, plaintiffs are resorting to ERISA to press for disclosure of financial incentives that health care providers use to contain costs, attorney says in an article discussing ERISA liability for non-disclosure of cost-control incentives. **Page 1934**

ALSO IN THE NEWS

DEFERRED COMPENSATION: IRS corrects final regulations on Section 457 deferred compensation plans. **Page 1897**

PREEMPTION: An employer's vacation plan is not governed by ERISA, and therefore a claim for benefits is not preempted, a federal court rules. **Page 1920**

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Until Congress or the Treasury Department come to some resolution on cash balance plans, the controversy will continue to be played out in the federal courts, especially as more and more employers convert to cash balance plans.

Before *Cooper*, participants who believed their cash balance plans discriminated on the basis of age had little ammunition given that no federal court had found such plans to be age-biased. *Cooper* could set the stage for even further litigation over the ever so controversial cash balance plan.

BY JO-EL J. MEYER

HIPAA Privacy

Tighter requirements over the sharing of information between health insurers, fully insured employers, and their brokers is one of many aspects of HIPAA privacy regulations that is causing confusion. Some say insurers are exercising necessary caution and that employers may be better off without the compliance problems associated with receiving such information, though others say it deprives employers of information necessary to get the most out of money spent on health insurance.

Health Insurers Cite HIPAA in Denying Employers Specific Claims Information

Final Health Insurance Portability and Accountability Act rules that took effect in April imposed tighter standards on many practices and business relationships involving health information. The rules pertaining to the sharing of information among a health insurer and a health plan, the plan sponsor, and an insurance broker are creating a great deal of confusion. In many cases insurers are denying specific claims information to fully insured employers who agree to certain safeguards, which insurance brokers, employers, and some attorneys complain is an overly cautious approach that will ultimately stifle competition and further escalate health costs.

Claims information can generally be provided to larger employers who are more likely to be self-insured or, if fully insured, have sufficient market power to gain the information. Small employers are unlikely to be affected because many state laws require that health plans for employers with a limited number of employees be based on geographic sampling of the community in which the employer is based, not on specific claims information for the group.

For those in between, brokers and some attorneys say, an absence of claims information beyond a one-line tally of total claims and total dollar amount paid deprives employers of necessary oversight and, perhaps more importantly, accurate figures used to negotiate premiums with the insurer or to shop for quotes from other insurers.

"Without that detailed claims experience, you might not get a quote at all, or get one that is exceedingly high," Karen Cox, vice president of employee benefits with IMA, an insurance brokerage in Wichita, Kan., told BNA Aug. 20.

Cox said detailed claims experience is necessary to identify large claimants or those with high risk, and in many cases that information evinces the fact that the claimant is no longer in the group or that the risk is not as bad as it appears. Such information is essential in gaining oversight to correct situations in which, for example, charges for an injury on the job are erroneously applied towards the plan instead of a separate workers' compensation plan.

"Without that detailed claims experience, you might not get a quote at all, or get one that is exceedingly high."

KAREN COX, IMA

Abby Waxenberg, a vice president in the group department at Singer Nelson Charlmers, an insurance broker in Teaneck, N.J., told BNA Aug. 25 that insurance companies are being overly cautious and using HIPAA as an excuse to withhold information. She recounted one situation in which, in the process of renewing an employer's contract, a major insurer declined to identify which of two employer offices an employee with a claim exceeding $150,000 worked.

Waxenberg said it is important that specific claims information be made available to brokers and employers to identify situations in which an employee with a large claim is no longer in the plan and therefore would not affect negotiations with another insurer. "If we can't get appropriate information, it makes it hard for us to negotiate," she said.

Sharing Allowed Under Certain Scenarios. Steven P. Smith, attorney at Hinkle Elkouri Law Firm in Wichita, told BNA Aug. 19 that many, but not all, insurance companies in Kansas have reacted to the new HIPAA rules

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by taking a very cautious approach in refusing to share specific claims information.

The regulations provide that insurance companies may share specific claims information in at least two scenarios. Under the regulations, covered entities that are part of an organized health care arrangement are free to disclose protected information to other covered entities that are part of the same arrangement, which Smith said opens up the channel of communication between insurance companies and insurance brokers that represent employers.

In the preamble to the regulations, the Department of Health and Human Services acknowledged that commenters had suggested that the permitted disclosures needed to be expanded to allow for disclosures between the insurance issuer and the plan or the broker for the purpose of performing functions related to supplementing or replacing coverage or to solicit bids from prospective issuers. HHS said that if more than summary information is needed, the definition of organized health care arrangement may permit the disclosure.

"These provisions define the arrangements between group health plans and their health insurance issuers or HMOs as OHCAs, which are permitted to share information for each other's health care operations. Such disclosures also may be made to a broker or agent that is a business associate of the health plan," the preamble states. HHS concluded that such an expansion was unnecessary because the existing regulations already allowed such information to be shared within an organized health care arrangement.

Additionally, the regulations permit employers to obtain specific claims information about their plan if they amend the plan documents required under the Employee Retirement Income Security Act and assume many of the same responsibilities in protecting the information that are applicable to insurers.

HHS's position on the issue is clear. Rick Campanelli, director of the HHS office of civil rights, told BNA Aug. 27 that there are three scenarios under which the employer can obtain such information. Employers are entitled to enrollment, disenrollment, and summary claims information.

If the employer wishes to use more specific information for renewal or replacement, then it can amend plan documents to provide for specific protections and describe how the information can be used for health care operations purposes. Then the employer can use the information for rating, underwriting, creation, renewal, or negotiating a health insurance contract because those functions fall under the umbrella of health care operations.

Under a third scenario, an employer can get a written authorization from every participant in the group to receive protected health information.

'Most Confusing Part of Confusing Law.' Kirk Nahra, a partner with Wiley Rein & Fielding's Washington, D.C., office, told BNA Aug. 22 that there is good news and bad news in sharing such information, because while a broker may be able to obtain such information on behalf of the employer, the receipt of such information may cause compliance problems.

Access to specific claims information and the accompanying plan document amendments makes employers who know little about health privacy subject to the same rules that apply to large insurance companies and other more sophisticated interests, he said.

"It's a very high risk area and everyone is trying to feel their way around it. The general sense I've gotten is that most employers do not get this stuff," Nahra said. "The local car dealership is not in the health care business."

One way to avoid such compliance problems is, in the same vein as getting authorization from all participants in the group, having all participants in the group apply for insurance with a new company such that the protected health information comes directly from those who are protected under HIPAA.

He said that brokers are not part of organized health care arrangements and in many cases do not have business associate agreements with employers they represent, which is requisite for the sharing of specific claims information.

Nahra acknowledged that the provisions governing the sharing of information between insurers, group health plans, and plan sponsors is "the most confusing part of a confusing privacy rule."

"The local car dealership is not in the health care business."

KIRK NAHRA, WILEY, REIN & FIELDING

Practical frustrations exist among employers who are used to doing what they have been doing in terms of their health plans. The regulations as they pertain to information shared between an insurance company and employer have produced a range of concerns and confusion among employers, and should be an eye-opener for HHS, which is more accustomed to writing rules for doctors and hospitals, Nahra said.

Insurers Take Cautious Interpretation. Correspondence provided to Smith by employers and insurance brokers suggests a variety of positions taken by insurance companies in denying specific claims information.

Some insurers said they have made a "corporate decision" not to provide specific claims information that includes protected health information of individuals within the group covered under the plan. Some said that they would require a signed release from each insured employee in order to provide such information, and that doing so without such releases would violate federal law.

Others note that while specific claims information could be presented in such a manner that scrambles some of the information, the information for a group, especially a small group, could still be tied back to individuals within the group based on identifying factors like age, sex, and point of service.

Those positions have the backing of the Health Insurance Association of America, a lobbying group.

HIAA spokesman Larry Akey told BNA Aug. 22 the association takes the position that any disclosure of personal medical information by health insurer would be considered a violation, or potential violation, of HIPAA. Insurers can disclose aggregate data and can disaggregate data to the level that personal health information is not disclosed, but nothing more.

"The rule seems to be clear enough," he said.

Akey said that even claims information that leaves out references to individuals can still be problematic, and appreciably more so for small employers. "If the employer is small and you break down the information too much, you encounter the situation in which everyone knows Sam had cancer and when chemotherapy shows up as a claim, it can be tied back to him," Akey said.

Brokers' Association Senses Problems. The National Association of Health Underwriters, the industry association that includes insurance brokers, clearly recognizes the delicacy of the situation.

A HIPAA compliance guide posted on NAHU's Web site reads: "Even though it may seem that the group health plan and the employer are indistinguishable, the group health plan is a separate entity. In order to disclose protected health information to a plan sponsor, either directly or though a health insurer or HMO, a group health plan must ensure that the plan document restricts the uses and disclosures of the information and the group health plan's notice of privacy practices must contain a statement that the group health plan makes disclosures to the plan sponsor.

"It is very important that the employer as plan sponsor receives only the information absolutely necessary to perform necessary administrative functions."

John Greene, NAHU managing director of federal affairs, told BNA Aug. 20 that the majority of insurance brokers have frequently faced barriers to claims information since the rule took effect. Interpretation of the new regulations is creating problems even in cases in which a plan participant's enrollment cannot be confirmed at a pharmacy counter and the insurance broker is contacted to confirm enrollment.

"The rule isn't intended to stymie doctors from getting lab reports and clients from getting medication," he said.

Greene said part of the problem is inconsistency among insurance companies, in that some consider employers to be business associates under the new regulations and some do not. He said he has not heard of any cases in which brokers and employers have been denied access to claims information for the purpose of negotiating rates or seeking bids from other insurers, but that could just be a matter of time.

Like Smith, Greene said that employers become engaged in such rate negotiations in the fall for rates that generally change with the calendar year, and frustrations over the lack of information to do so effectively could surface as the season draws near. "October, November is when the issue is really going to hit, when people go to their insurance company for information for quotes," Smith said.

Greene said NAHU is looking to meet with HHS soon to encourage them to express their position on the issue in writing.

Federal and State Jurisdiction. But, as several sources point out, the issue falls on a crossroads of jurisdiction because HIPAA is a federal law but insurance companies are regulated on a state-by-state basis.

Mark Lutes, a partner in Epstein Becker & Green P.C.'s Washington, D.C., office, told BNA Aug. 22 that with regard to insurance companies providing employers with specific claims information, "there are two bodies of law that have to be understood in making the determination: whether it is within the permissible disclosures under health care operations under HIPAA analysis; and, second, whether specific claims are releasable under state insurance law. Both of those have issues."

With regard to state law, it is frequently allowable to release claims information in the context of an audit for reporting purposes, though information requested by employers may be more specific than that, Lutes said. "There has got to be an examination of state law to understand whether claim-specific data is within the law," he said.

But, he said, there is a fair degree of commonality because states often will have adopted one of two National Association of Insurance Commissioner's model laws, with about one-third of states adopting one, one-third adopting the other, and another one-third doing something different. Thus, even if HHS made a determination, there would still be ambiguity among state laws.

And Lutes said state issues complicate the issue for large insurance companies because it could be relatively burdensome for them to be able to come up with a policy that works across all 50 states.

Escalating Health Costs. Frank. F. Haack & Associates, a brokerage and consulting firm in Milwaukee, provides clients with a data analysis tool that requires specific claims information to be of any use to clients. Difficulty in getting that information quashes the utility of the data analysis.

Dave O'Brien, vice president for marketing at Haack & Associates, told BNA Aug. 25 that the data analysis, which looks at factors like how many employees in the group went for office visits during the course of the year, is essential in showing employers how their insurance dollars are being spent and, in turn, how they can be spent more efficiently.

For example, if the data analysis is showing that the majority of office visits are related to a similar illness or the management of the same disease, the employer could, based on that knowledge, bring in physicians to educate the group or take other preventive steps that benefit all those involved. Demographics are also made clearer by the data analysis, which may show that a group has a high number of office visits related to pregnancy and could suggest that the employer should establish a healthy pregnancy program.

"Clearly, a printing shop in town is going to have a different set of demographics than a high-technology firm that is more likely to employ younger workers," O'Brien said. He believes carriers who aid brokers and consultants in giving them data will benefit versus those using HIPAA as an excuse.

Several sources agreed that the lack of information robs brokers and employers of decisionmaking ability, both in terms of whether they are entitled to claims information and how to use it to make the plan more accommodating.

"If you can't figure out where the dollars are being spent, you can't make the appropriate design changes," Waxenberg, of Singer Nelson Charlmers, said.

She said any attempts to further the concept of consumer directed health care—by which employees are given more control over how their health dollars are spent in an effort to make that spending more targeted and efficient—could be stymied by insurers' cautious approach.

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Smith, with the Hinkle Elkouri firm, likewise said withholding information compromises an employer's role in providing benefits to its employees. "It's not the role of the insurance company to second-guess whether or not an employer 'really' needs the information it has requested," he said.

Smith said a primary concern with the drought of information is that premiums, which increased by 25-40 percent for many employers this year, are going to increase by a similar amount next year. Without specific claims information, quotes from other insurance companies will not be competitive, largely because of concerns about an employer having a hidden health risk in group, he said.

Regardless of how the information is used, insurers' caution is seen as compromising the autonomy of employers in determining whether they need the information.

"Either insurers are misinterpreting the law or taking an extremely conservative approach—telling the client, 'We know what's best for you more than you do,' " IMA's Cox said. "With medical trends continuing at double-digit pace and no hopes of them slowing down anytime soon, the withholding of information will drive us quicker to unaffordable health care and ultimately a larger population of uninsured."

By Kurt Ritterpusch

HINKLE
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LAW FIRM L.L.C.

FILE COPY

Reply to Main Office
Steven P. Smith
Direct fax 660-6010
ssmith@hinklaw.com

June 18, 2003

Richard Huncker
Kansas Insurance Department
420 SW 9th Street
Topeka, Kansas 66612-1678

Re: Thayer Aerospace Consolidated, LLC
– Coventry Health Care of Kansas, Inc. - Department File No. 0303CA106504

Dear Mr. Huncker:

On behalf of our client, Thayer Aerospace Consolidated, LLC, we want to express our appreciation for the efforts that the Kansas Insurance Department has been making toward working out the problems that have surfaced as the insurance companies in this state have changed their practices in response to the HIPAA Medical Privacy Regulations.

The problem that is of the greatest concern at this time is the refusal of certain insurance companies to share claims information with their policyholders. As you noted in your letter of June 3, 2003, an employer that is sponsoring a group health plan for its employees needs to obtain some amount of claims information in order to properly manage its plan. Without this information an employer-plan sponsor will not be able to determine if the plan is being operated in accordance with its terms, it will not know whether or not claims are being processed correctly, and it has a difficult time in obtaining competitive bids for coverage from other insurance companies.

ASSERTIONS MADE BY COVENTRY

In its letter to you dated May 30, 2003, Coventry asserts that the HIPAA Medical Privacy Regulations prohibit the sharing of any information that includes "the names of individual employees and family members who have incurred large medical expense claims, and the associated claim history detail." This is not, however, what the regulations actually say.

Coventry asserts that the only information it may share without the consent of an individual is "summary health information" and "de-identified health information." ***Coventry does not, however, address the portion of the regulations that permits the sharing of "protected health information" within an "organized health care arrangement," nor does it address the provisions that allow "protected health information" to be disclosed to the plan sponsor for "plan administration functions"*** if certain conditions (such as amending the plan document) have been met.

SHARING "PROTECTED HEALTH INFORMATION" WITHIN AN "ORGANIZED HEALTH CARE ARRANGEMENT"

Under the regulations, the arrangement between a fully insured group health plan and its health insurance issuer constitutes an "organized health care arrangement" ("OHCA"). 45 CFR § 164.501(3). The regulations expressly provide that a "covered entity" that participates in an OHCA ***"may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement*** for any health care operations activities of the organized health care arrangement." 45 CFR § 164.506(c)(5) (emphasis added).

The preamble to the regulations explains that this provision was included in the regulations for the express purpose of authorizing the disclosure of "protected health information" from a health insurance issuer to a fully insured group health plan and its "business associates." Quoting from the preamble:

> [A] few commenters raised similar concerns that the Department's proposal ... ***would not allow for the disclosures between a health insurance issuer and a group health plan, or the agent or broker as a business associate of the plan***, needed to perform functions related to supplementing or replacing insurance coverage, such as to solicit bids from prospective issuers. The Department clarifies that, ***if more than summary health information is needed for this purpose, paragraphs (3), (4), and (5) of the definition of "organized health care arrangement" may permit the disclosure.*** These provisions define the arrangements between group health plans and their health insurance issuers or HMOs as OHCAs, which are permitted to share information for each other's health care operations. ***Such disclosures also may be made to a broker or agent that is a business associate of the health plan.*** The Department clarifies that ***the OHCA provisions also permit the sharing of protected health information between such entities even when they no longer have a current relationship, that is, when a group health plan needs protected health information from a former issuer.*** The Department, therefore, does not believe that a broadening of the provisions under Sec. 164.506(c)(4), to allow disclosures of protected health information for other types of health care operations activities, is warranted.

67 Fed. Reg. at 53217 - 18 (Aug. 14, 2002) (emphasis added).

Thus, the regulations expressly permit a current or former insurance carrier to share "protected health information" with a group health plan. The regulations further permit a group health plan that has received "protected health information" in this way to share that information with its insurance brokers and other "business associates."

No special arrangements or conditions are required to be satisfied in order to share information within an OHCA. If an OHCA exists, "protected health information" may be shared.

SHARING "PROTECTED HEALTH INFORMATION" FOR "PLAN ADMINISTRATION FUNCTIONS"

Under the regulations, and as we noted in our letter to Commissioner Praeger dated April 24, 2003, a "health insurance issuer," such as Coventry, is permitted to disclose "protected health information" if an employer-plan sponsor requests that information in order to perform "plan administration functions" and if certain conditions are met. 45 CFR § 164.504(f)(3).

The regulations define "plan administration functions" as functions that are "performed by the plan sponsor of a group health plan on behalf of the group health plan." 45 CFR § 164.504(a). As examples of such functions, the preamble to the regulations lists such activities as ***quality assurance, claims processing, auditing, monitoring, and the management of carve-out plans, such as vision and dental.*** 65 Fed. Reg. at 82508 (Dec. 28, 2000).

As a condition of receiving "protected health information" in order to perform a "plan administration function," an employer-plan sponsor must amend the plan document to include specific provisions relating to the use and disclosure of any PHI that the employer receives. Among other things, the amendments must describe the employees who are allowed to receive the information, must restrict access and use of the "protected health information" to those employees, and must provide "an effective mechanism for resolving any issues of noncompliance" by such employees. Additionally, the employer must certify that the plan document has been amended and that it agrees to the restrictions set forth in the amendments. 45 CFR § 164.504(f)(3).

If these conditions are met, the employer is entitled to receive "protected health information" from the plan and from the plan's "health insurance issuer." We would note that this understanding of what the regulations do or do not allow is consistent with the views Commissioner Praeger has expressed. In her letter to Buz Lukens of IMA dated May 21, 2003, she wrote the following:

> We have read Mr. Steven Smith's letter of April 24, 2003. We agree that the HIPAA Medical Privacy law does not "prevent" a health insurer from sharing certain information with an employer-plan sponsor. Within the framework of the federal medical privacy act, insurance companies can provide, with some limitations, more than aggregate claim information.

We would also note that other insurance companies doing business in Kansas have come to the same conclusion. For example, Blue Cross Blue Shield of Kansas, Inc., originally took the position that the HIPAA Medical Privacy Regulations prevented it from sharing any "protected health information" with plan sponsors that were fully insured. After some back and forth, however, Blue Cross ended up agreeing that information could be shared with the plan sponsor and that it would continue to provide reports containing "protected health information" if the plan sponsor represented that it had taken whatever steps were necessary under the regulations in order for it to continue receiving that information.

Finally, we would note that the sharing of "protected health information" with an employer-plan sponsor for "plan administration functions" is ***not*** contrary to Coventry's business practices as set forth in the Privacy Notice that was enclosed with its letter of May 30, 2003. There is nothing in this Notice that states that "protected health information" will not be shared with an employer-plan sponsor. In fact, the

Notice actually states that such information may be shared. Looking at the third page of the Notice, we see the following:

> *E. What Other Ways Do We Use or Share Your Information?*
>
> We may also use or share you [sic] personal information for the following:
>
> ... **Plan Sponsors:** To permit the sponsor of your health plan to service your benefits. Please see your plan documents for more information.

It is difficult to see this as anything other than an acknowledgment that "protected health information" may be shared with the employer-plan sponsor for "plan administration functions" and that the provisions adopted by the plan sponsor in its plan documents will control as to what information is shared.

CONCLUSION

We continue to strongly believe that our client is entitled to receive the information it has requested from Coventry. To say that the HIPAA Medical Privacy Regulations "prevent" a health insurance issuer, such as Coventry, from sharing information with an employer-plan sponsor, such as Thayer Aerospace, is quite simply wrong. There is nothing in the regulations that prohibits an employer from receiving information if that information is needed for a legitimate purpose and if the employer has satisfied the conditions, if any, that regulations impose for receiving information for that purpose.

We appreciate the efforts you have made to establish a dialogue with Coventry. We hope that Coventry will be willing to re-examine its position based on the portions of the regulations that we have cited in this letter. We look forward to continuing this dialogue with your office and with Coventry.

If you have any questions about any of the matters discussed in this letter or about the HIPAA Medical Privacy Regulations as they affect employers, please do not hesitate to contact our office.

Sincerely,

HINKLE ELKOURI LAW FIRM L.L.C.

Steven P. Smith

cc: Carole Ochs, Vice President Human Resources, Thayer Aerospace Consolidated, LLC
Buz Lukens, IMA
Karen Cox, IMA

HINKLE
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Reply to Main Office
Steven P. Smith
Direct fax 660-6010
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April 24, 2003

Sandy Praeger
Commissioner of Insurance
Kansas Insurance Department
420 SW 9th Street
Topeka, Kansas 66612-1678

Re: Thayer Aerospace Consolidated, LLC
– Coventry Health Care of Kansas, Inc. - Department File No. 0303CA106504

Dear Ms. Praeger:

On behalf of our client, Thayer Aerospace Consolidated, LLC, we want to express our appreciation for your prompt response to our client's letter of March 12, 2003. In that letter, our client expressed its concern that Coventry Health Care was not providing information it needed to manage its health care plan and to obtain competitive quotes from other insurance carriers. In response to our client's letter, your office contacted Coventry and obtained a written response dated April 4, 2003, which was forwarded to our client on April 8, 2003.

Unfortunately, Coventry's response does not adequately address our client's concerns. Coventry stated in its response that, under federal law, it is not allowed to release the information that our client requested unless our client first provides a signed release from each insured employee. We do not believe that this is what the federal law actually provides. Instead, we believe that Coventry has misunderstood the privacy requirements found in the HIPAA Medical Privacy Regulations (45 CFR § 160.101 et seq.).

In our view, there is nothing in the regulations that would prevent Coventry from providing the information requested by our client. In fact, we believe that our client is entitled to receive this information from Coventry so long as the conditions set forth in the regulations are met.

HIPAA Medical Privacy Regulations

The HIPAA Medical Privacy Regulations were issued in final form on December 28, 2000, and were modified on August 14, 2002. For most "covered entities," the regulations took effect on April 14, 2003. 45 CFR § 164.534. For most employer-sponsored group health plans in Kansas, however, the regulations have not yet taken effect. Under the regulations, "small health plans" are not required to comply with the regulations until April 14, 2004. 45 CFR § 164.534(b)(2). For this purpose, a "small health plan" is a plan that paid $5 million or less in annual premiums during its most recent plan year if the plan was fully-insured

or a plan that paid $5 million or less in claims during its most recent plan year if the plan was self-insured. 45 CFR § 160.103.

The basic rule set forth in the regulations is that a "covered entity" may not use or disclose an individual's "protected health information" (or "PHI") *except* as permitted by the regulations. 45 CFR § 164.502(a). The regulations then go on to set forth a number of specific situations in which PHI may be used or disclosed.

As referenced in the letter that Coventry sent to your office, PHI may be used or disclosed when an individual has signed an "authorization" permitting the use or disclosure. 45 CFR § 164.502(a)(1)(iv). This is *not*, however, the only situation in which the regulations allow PHI to be used or disclosed.

The regulations expressly allow PHI to be shared with an employer that is sponsoring a "group health plan," such as Thayer Aerospace, if certain conditions are met. The amount of PHI that may be shared and the conditions that must be satisfied before that information can be shared depend on the purpose for which the employer has requested the information.[1]

SHARING INFORMATION FOR UNDERWRITING AND/OR PLAN AMENDMENT PURPOSES

If an employer-plan sponsor requests information for the purpose of "obtaining premium bids from health plans for providing health insurance coverage under the group health plan" or for the purpose of "modifying, amending, or terminating the group health plan," a "health insurance issuer," such as Coventry, is permitted to disclose "summary health information." 45 CFR § 164.504(f)(1)(ii).

"Summary health information" is defined as information that "summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan" and from which certain identifying information has been removed. 45 CFR § 164.504(a). Although certain information must be removed before "summary health information" can be shared with an employer-plan sponsor, "summary health information," as defined in the regulations, still contains information that is detailed and useful. It is much more than the total dollar amount of claims paid. The regulations contemplate that "summary health information" will contain information about the claims incurred by *each* person covered under the plan, including type of treatment and the dollar amount of the claim, so long as the identifying information for that person has been removed.

---

[1] We would note that, although Coventry became subject to the regulations earlier this month, our client's group health plan is a "small" plan that will not be subject to the regulations until April of next year. Until the regulations do become effective as to our client's group health plan, there is nothing that would prohibit the plan from continuing to share information with our client. The fact that such information sharing may take place over the next year should not present any concerns to Coventry. Under the regulations, as modified in August 2002, the arrangement between a fully insured plan and its health insurance issuer constitutes an "organized health care arrangement" ("OHCA"). 45 CFR § 164.501. The regulations expressly provide that a "covered entity" that participates in an OHCA "may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement." 45 CFR § 164.506(c)(5). Thus, Coventry is expressly permitted to share PHI with our client's plan without regard to the fact that our client's plan will not be required to comply with the regulations until April of next year.

There are no other conditions that must be met if an employer wants to receive "summary health information" for underwriting purposes or for purposes of considering a change in the benefits that are being offered. If an employer is sponsoring a "group health plan" and the employer requests "summary health information" for either of these two purposes, that information may be shared.

SHARING INFORMATION FOR PLAN ADMINISTRATION PURPOSES

A "health insurance issuer" is also permitted to disclose PHI if an employer-plan sponsor requests that information in order to perform "plan administration functions" and if certain conditions are met. 45 CFR § 164.504(f)(3).

"Plan administration functions" are defined as follows:

> *Plan administration functions* means administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

45 CFR § 164.504(a). As examples of "plan administration functions," the preamble to the regulations lists such activities as quality assurance, claims processing, auditing, monitoring, and the management of carve-out plans, such as vision and dental. 65 Fed. Reg. at 82508 (Dec. 28, 2000).

As a condition of receiving PHI in order to perform a "plan administration function," an employer-plan sponsor must amend the plan document to include specific provisions relating to the use and disclosure of any PHI that the employer receives. Among other things, the amendments must describe the employees who are allowed to receive the information, must restrict access and use of the PHI to those employees, and must provide "an effective mechanism for resolving any issues of noncompliance" by such employees. Additionally, the employer must certify that the plan document has been amended and that it agrees to the restrictions set forth in the amendments. 45 CFR § 164.504(f)(3).

If these conditions are met, the employer is entitled to receive PHI from the plan and from the plan's "health insurance issuer."

REASONS AN EMPLOYER MIGHT WANT TO RECEIVE PHI FROM A HEALTH INSURANCE ISSUER

Given fiduciary responsibilities that an employer has under ERISA with respect to the operation of its "employee welfare benefit plans," it is our expectation that many employers, particularly larger employers, will feel that they need to receive PHI in order to ensure that their plan is being administered according to the terms and conditions of the plan document. In particular, we expect that many employers will want to receive PHI in order to ensure that claims are being correctly processed.

Although most insurance carriers are diligent about processing claims, there are times when the employer may be in a better position than the insurance carrier to flag claims that are not properly payable by the employer's plan. Consider, for example, the following situations:

(1) **Coordination of Benefits.** There are times when a claim should be paid by someone other than the employer's group health. For example, if a covered employee is injured while at work, the claim may be one that should have been paid through the worker's compensation system rather than under the group health plan. The employer will ordinarily be aware of injuries that are job-related and is therefore in a good position to detect claims that should be routed through the worker's compensation system. The insurance carrier for the plan, on the other hand, will not necessarily know that a particular claim is arising out of a work-related injury.

(2) **Person is Not Covered Under the Plan.** There are times when a claim is incurred for a person who is not covered under the plan. For example, it may be that the person is no longer part of the group. This could include a person who is no longer employed by the employer and who did not elect COBRA. It could also include a divorced spouse who is still being covered as a dependent (rather than as a COBRA beneficiary) because the employee failed to inform the group health plan of the divorce. Or, it could be a situation in which the person was never part of the group but the claim was posted to the group by mistake. An employer will frequently be in a better position than an insurance carrier to identify such claims.

(3) **Benefits are Not Payable Under the Plan.** It sometimes happens that a claim is filed for a benefit that is not provided by the plan. Although one would generally expect an insurance company to know what benefits are payable and what are not, mistakes may happen. If the employer does not receive detailed information about the claims that have been paid, it is possible that a mistake of this type would never be caught.

CONCLUSION

To say that the HIPAA Medical Privacy Regulations "prevent" a health insurance issuer, such as Coventry, from sharing information with an employer-plan sponsor, such as Thayer Aerospace, is wrong. There is nothing in the regulations that prohibits an employer from receiving information if that information is needed for a legitimate purpose and if the employer has satisfied the conditions, if any, that regulations impose for receiving information for that purpose.

Employers have the responsibility to obtain coverage for their group health plans and to ensure that those plans are being administered correctly according to their terms. To carry out this responsibility, they need to receive information from their health insurance issuer.

For their part, health insurance issuers have a responsibility to read the regulations carefully and in light of their stated purpose. The regulations were not intended to cut off the flow of information between an employer and a health insurance issuer and they were not intended to remove the employer from any type of oversight role for its group health plan.

If an insurance company wants to say that, "because" of the regulations, it will no longer share any amount of meaningful information with an employer, that insurance company is really saying that it is not willing to put forth the effort that is required to read and understand the regulations to which it is subject. In a health care system in which we are all dependent, to some extent, upon others, this abdication of responsibility cannot be excused. If the insurance companies are not willing to share information with employers, the system will not work. Costs will increase, employers will reduce the benefits they are offering, and employees and their families will lose out.

We would respectfully submit that your office should look into this situation and that it should encourage, and even prod, the insurance companies it regulates to cooperate with employers in sharing the information that employers need to obtain coverage and to oversee the operation of their group health plans.

We appreciate the attention you have already paid to this matter and look forward to working with your office to resolve these concerns in a way that will be beneficial for everyone concerned. If you have any questions about any of the matters discussed in this letter or about the HIPAA Medical Privacy Regulations as they affect employers, please do not hesitate to contact our office.

Sincerely,

HINKLE ELKOURI LAW FIRM L.L.C.

Steven P. Smith

Enclosures
cc: Carole Ochs, Vice President Human Resources, Thayer Aerospace Consolidated, LLC
Buz Lukens, IMA
Karen Cox, IMA

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

May 21, 2003

Mr. Buz Lukens
President
IMA
PO Box 2992
Wichita, KS 67201-2992

Dear Mr. Lukens:

Thank you for your letter of May 7, 2003.

Kansas insurance laws do not require insurance companies to provide medical claim information when requested by their group policyholders. Therefore, insurance companies are under no obligation to provide such information unless the negotiated group contract specifically requires the insurance company to provide medical claim information.

In the past, some companies have been willing to provide more than aggregate information. However, with the enactment of HIPAA/Health Insurance Portability Access and Accountability Act, there are limitations on providing individual medical claim information unless the insured employee signs a release.

We have read Mr. Steven Smith's letter of April 24, 2003. We agree that the HIPAA Medical Privacy law does not "prevent" a health insurer from sharing certain information with an employer-plan sponsor. Within the framework of the federal medical privacy act, insurance companies can provide, with some limitations, more than aggregate claim information. My staff has contacted Coventry in an effort to see if the company would be willing to provide additional medical claim information. Coventry will be getting back to us within the next few days. We will contact Carole Ochs with regard to our discussions with Coventry.

As a result of your inquiry, I have asked my staff to gather information which may be used to develop a legislative proposal for 2004 which requires the availability of medical claim information from insurers. I totally agree with your comments that the exchange of information would be of benefit to policyholders in the administration of their group health insurance plan. As you pointed out in your letter, by increasing access to medical claim information, we allow insurance companies to provide affordable health care to their employees in Kansas.

420 SW 9TH STREET
TOPEKA, KANSAS 66612-1678

PHONE 785.296.3071
FAX 785.296.2283

CONSUMER HOTLINE
1.800.432.2484

WEBSITE
www.ksinsurance.org

To reiterate, without specific legislative authority, I cannot demand insurance companies to provide the medical claim information you desire. Hopefully, if this issue is discussed by the next session of our legislature it will be given serious consideration.

Sincerely,

Sandy Praeger

Sandy Praeger
Commissioner of Insurance

cc: Carole Ochs, Thayer Aerospace
Steven P. Smith, Hinkle Elkouri Law Firm L.L.C.

THAYER AEROSPACE

February 17, 2004

Good Afternoon Representatives / Senators, Ladies and Gentleman:

My name is Carole Ochs, I am the Vice President of Human Resources for Thayer Aerospace in Wichita, Kansas. I wish to thank you in advance for your time and attention and for allowing me to voice my support for the proposed House Bill No. 2689, mandating insurance carriers provide detailed claims utilization to employers.

I am here today to alert you to an unfair business practice affecting Kansas employers. Our healthcare insurance provider is taking full advantage of a loophole in HIPPA laws and are manipulating it to their advantage. Our carrier refuses to share claim utilization data claiming they would be in violation of HIPPA laws.

The issue today is *not* about HIPPA per say rather the impropriety of carriers taking advantage of their clients and hiding behind ambiguous verbiage. HIPPA came into existence to protect patient's rights. The healthcare insurance providers are in turn using this HIPPA loophole to their advantage and are hurting the very individuals HIPPA protects.

As you are well aware, Wichita businesses are suffering one of the worst economic downturns in years while aerospace companies continue to downsize or fold. We are now further burdened with continued double-digit rate increases in our healthcare insurance premiums. Because of this, it is imperative employers control costs if they struggle to remain in business.

Thayer Aerospace employs 250 Kansans and spends over $1.8MM annually to provide employees with healthcare insurance. Without claim information I cannot effectively manage our healthcare dollars, nor can I competitively market our company to other carriers. Other carriers require 12 months of claim data in order to propose healthcare plans. Without this data I am hostage to my current carrier. The past two years we have been presented with repeated increases, my carrier defends their actions by stating "our claim information" justifies the increases. There is no hope of another carrier willing to competitively quote our business without our utilization history. By withholding access to our claims data we cannot obtain the lowest cost health insurance. This will cost us tremendous amounts of money which may ultimately force us to drop company sponsored health plans in order to stay in business.

House Insurance
Date: 2/17/04
Attachment # 10

As an employer we are required by law to comply with HIPPA laws and regulations which means policies and processes must be in place ensuring claims information is secure and treated as private information. We have a legal requirement as well as an ethical obligation not to use this information in making employment decisions. It has not been; or will be a practice of Thayer Aerospace to discriminate against employees due to health conditions.

By withholding claim information we cannot design healthcare benefits to meet the varied needs of our employees. This data provides great insight as to the health conditions of our employees so we can design a health plan to meet their specific needs. We consider many elements of plan design changes based on our claim activity. Perhaps a better prescription drug benefit is needed, or higher deductibles or office co-pays are in order. Last year we learned only two employees used the chiropractic care benefit in our plan. By removing this benefit we saved tens of thousands of dollars. We also learned of an error in the claim data where a former employee was listed as a COBRA participant, but his COBRA had expired, we had to inform the carrier of this. Again, there are no checks and balances to ensure the claim information they are using is correct.

Here's an analogy that demonstrates how this loophole would impact you if applied to another necessity of life—your car. Imagine your car stalls tonight as you are driving home after work. You see your auto mechanic (insurance provider), and he says your car has something wrong which requires $5,000 to fix. You ask the mechanic exactly what is wrong with your car but he replies, "I'm sorry but due to HIPPA laws I cannot tell you." How do you respond? You look for a new mechanic of course, but you find that every mechanic you talk to is using the same HIPPA excuse.

I respectfully request that you vote in support of proposed House Bill No. 2689, mandating insurance carriers provide claims utilization to employers. Remove the loophole and force them to conduct business fairly and honestly. Help Kansas employers control costs and help our employees to afford healthcare insurance.

Thank you,

Carole Ochs
Vice President Human Resources
Thayer Aerospace

10-2

THAYER AEROSPACE

March 12, 2003

Kansas Insurance Department
Consumer Affairs Division
420 SW 9th
Topeka, KS 66612-1678

Gentlemen/Ladies:

The cost of our health insurance is rising rapidly. In order to properly manage our health care plan and be able to obtain competitive quotes from other insurance carriers, it is imperative that we be able to properly assess the health risk within our own company.

Coventry Health Care is holding Thayer Aerospace hostage by withholding claims information. Coventry HealthCare is refusing to give any detailed information to either Thayer or our insurance broker, IMA of Kansas, Inc. They are willing to give us "total" claims dollars paid and "total" premium paid, however, without specific data, we are unable to offer wellness programs designated to target specific conditions and are unable to obtain competitive quotes, as companies will not quote without detailed claims data.

We are asking that you help us obtain this information so that we can not only properly manage our risk but also allow us to competitively market our account to other insurance carriers. As an employer with 200+ employees, it is imperative that we continue to offer a very competitive benefit package to our employees.

I look forward to a response from your office in helping to obtain the information we need by March 17, 2003.

Sincerely,

Carole Ochs

Carole Ochs
Vice President Human Resources
Thayer Aerospace Coroporate

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10-3

Kansas Insurance Department

Sandy Praeger COMMISSIONER OF INSURANCE

April 8, 2003

CAROL OCHS
VICE PRESIDENT of HUMAN RESOURCES
THAYER AEROSPACE CORPORATION
4201 S 119th ST WEST
WICHITA, KS 67215

Re: Coventry Health Care
Kansas Insurance Dept. File Number: 0303CA106504

Ms. Ochs:

Enclosed is a copy of the letter that we received from the above company in response to your inquiry.

The company's letter appears to be self-explanatory, and Ms. Tenute has enclosed the information regarding Regulations for the U.S. Department of Health and Human Services. Unless we hear from you to the contrary, we will assume that this matter is satisfactorily resolved.

If you have further questions regarding this or any other insurance matter, please do not hesitate to contact us.

Sincerely,

Claudia Perney

Claudia Perney,
Health, Accident, and Life Representative
Consumer Assistance Division

Enclosure

10-4

(1) *Disclosures by whistleblowers.* A covered entity is not considered to have violated the requirements of this subpart if a member of its workforce or a business associate discloses protected health information, provided that:

(i) The workforce member or business associate believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public; and

(ii) The disclosure is to:

(A) A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity; or

(B) An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to the conduct described in paragraph (j)(1)(i) of this section.

(2) *Disclosures by workforce members who are victims of a crime.* A covered entity is not considered to have violated the requirements of this subpart if a member of its workforce who is the victim of a criminal act discloses protected health information to a law enforcement official, provided that:

(i) The protected health information disclosed is about the suspected perpetrator of the criminal act; and

(ii) The protected health information disclosed is limited to the information listed in § 164.512(f)(2)(i).

§ 164.504 Uses and disclosures: organizational requirements.

(a) *Definitions.* As used in this section:

Common control exists if an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of another entity.

Common ownership exists if an entity or entities possess an ownership or equity interest of 5 percent or more in another entity.

Health care component means a component or combination of components of a hybrid entity designated by the hybrid entity in accordance with paragraph (c)(3)(iii) of this section.

Hybrid entity means a single legal entity:

(1) That is a covered entity;

(2) Whose business activities include both covered and non-covered functions; and

(3) That designates health care components in accordance with paragraph (c)(3)(iii) of this section.

Plan administration functions means administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

Summary health information means information, that may be individually identifiable health information, and:

(1) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

(2) From which the information described at § 164.514(b)(2)(i) has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

(b) *Standard: health care component.* If a covered entity is a hybrid entity, the requirements of this subpart, other than the requirements of this section, apply only to the health care component(s) of the entity, as specified in this section.

(c)(1) *Implementation specification: application of other provisions.* In applying a provision of this subpart, other than this section, to a hybrid entity:

(i) A reference in such provision to a "covered entity" refers to a health care component of the covered entity;

(ii) A reference in such provision to a "health plan," "covered health care provider," or "health care clearinghouse" refers to a health care component of the covered entity if such health care component performs the functions of a health plan, health care provider, or health care clearinghouse, as applicable; and

(iii) A reference in such provision to "protected health information" refers to protected health information that is created or received by or on behalf of the health care component of the covered entity.

(2) *Implementation specifications: safeguard requirements.* The covered entity that is a hybrid entity must ensure that a health care component of the entity complies with the applicable requirements of this subpart. In particular, and without limiting this requirement, such covered entity must ensure that:

(i) Its health care component does not disclose protected health information to another component of the covered entity in circumstances in which this subpart would prohibit such disclosure if the health care component and the other component were separate and distinct legal entities;

(ii) A component that is described by paragraph (c)(3)(iii)(B) of this section does not use or disclose protected health information that it creates or receives from or on behalf of the health care component in a way prohibited by this subpart; and

(iii) If a person performs duties for both the health care component in the capacity of a member of the workforce of such component and for another component of the entity in the same capacity with respect to that component, such workforce member must not use or disclose protected health information created or received in the course of or incident to the member's work for the health care component in a way prohibited by this subpart.

(3) *Implementation specifications: responsibilities of the covered entity.* A covered entity that is a hybrid entity has the following responsibilities:

(i) For purposes of subpart C of part 160 of this subchapter, pertaining to compliance and enforcement, the covered entity has the responsibility to comply with this subpart.

(ii) The covered entity has the responsibility for complying with § 164.530(i), pertaining to the implementation of policies and procedures to ensure compliance with this subpart, including the safeguard requirements in paragraph (c)(2) of this section.

(iii) The covered entity is responsible for designating the components that are part of one or more health care components of the covered entity and documenting the designation as required by § 164.530(j), provided that, if the covered entity designates a health care component or components, it must include any component that would meet the definition of covered entity if it were a separate legal entity. Health care component(s) also may include a component only to the extent that it performs:

(A) Covered functions; or

(B) Activities that would make such component a business associate of a component that performs covered functions if the two components were separate legal entities.

(d)(1) *Standard: affiliated covered entities.* Legally separate covered entities that are affiliated may designate themselves as a single covered entity for purposes of this

subpart.

(2) *Implementation specifications: requirements for designation of an affiliated covered entity.*

(i) Legally separate covered entities may designate themselves (including any health care component of such covered entity) as a single affiliated covered entity, for purposes of this subpart, if all of the covered entities designated are under common ownership or control.

(ii) The designation of an affiliated covered entity must be documented and the documentation maintained as required by § 164.530(j).

(3) *Implementation specifications: safeguard requirements.* An affiliated covered entity must ensure that:

(i) The affiliated covered entity's use and disclosure of protected health information comply with the applicable requirements of this subpart; and

(ii) If the affiliated covered entity combines the functions of a health plan, health care provider, or health care clearinghouse, the affiliated covered entity complies with paragraph (g) of this section.

(e)(1) *Standard: business associate contracts.*

(i) The contract or other arrangement between the covered entity and the business associate required by § 164.502(e)(2) must meet the requirements of paragraph (e)(2) or (e)(3) of this section, as applicable.

(ii) A covered entity is not in compliance with the standards in § 164.502(e) and paragraph (e) of this section, if the covered entity knew of a pattern of activity or practice of the business associate that constituted a material breach or violation of the business associate's obligation under the contract or other arrangement, unless the covered entity took reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful:

(A) Terminated the contract or arrangement, if feasible; or

(B) If termination is not feasible, reported the problem to the Secretary.

(2) *Implementation specifications: business associate contracts.* A contract between the covered entity and a business associate must:

(i) Establish the permitted and required uses and disclosures of such information by the business associate. The contract may not authorize the business associate to use or further disclose the information in a manner that would violate the requirements of this subpart, if done by the covered entity, except that:

(A) The contract may permit the business associate to use and disclose protected health information for the proper management and administration of the business associate, as provided in paragraph (e)(4) of this section; and

(B) The contract may permit the business associate to provide data aggregation services relating to the health care operations of the covered entity.

(ii) Provide that the business associate will:

(A) Not use or further disclose the information other than as permitted or required by the contract or as required by law;

(B) Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by its contract;

(C) Report to the covered entity any use or disclosure of the information not provided for by its contract of which it becomes aware;

(D) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from, or created or received by the business associate on behalf of, the covered entity agrees to the same restrictions and conditions that apply to the business associate with respect to such information;

(E) Make available protected health information in accordance with § 164.524;

(F) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with §164.526;

(G) Make available the information required to provide an accounting of disclosures in accordance with § 164.528;

(H) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the business associate on behalf of, the covered entity available to the Secretary for purposes of determining the covered entity's compliance with this subpart; and

(I) At termination of the contract, if feasible, return or destroy all protected health information received from, or created or received by the business associate on behalf of, the covered entity that the business associate still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(iii) Authorize termination of the contract by the covered entity, if the covered entity determines that the business associate has violated a material term of the contract.

(3) *Implementation specifications: other arrangements.*

(i) If a covered entity and its business associate are both governmental entities:

(A) The covered entity may comply with paragraph (e) of this section by entering into a memorandum of understanding with the business associate that contains terms that accomplish the objectives of paragraph (e)(2) of this section.

(B) The covered entity may comply with paragraph (e) of this section, if other law (including regulations adopted by the covered entity or its business associate) contains requirements applicable to the business associate that accomplish the objectives of paragraph (e)(2) of this section.

(ii) If a business associate is required by law to perform a function or activity on behalf of a covered entity or to provide a service described in the definition of *business associate* in § 160.103 of this subchapter to a covered entity, such covered entity may disclose protected health information to the business associate to the extent necessary to comply with the legal mandate without meeting the requirements of this paragraph (e), provided that the covered entity attempts in good faith to obtain satisfactory assurances as required by paragraph (e)(3)(i) of this section, and, if such attempt fails, documents the attempt and the reasons that such assurances cannot be obtained.

(iii) The covered entity may omit from its other arrangements the termination authorization required by paragraph (e)(2)(iii) of this section, if such authorization is inconsistent with the statutory obligations of the covered entity or its business associate.

(4) *Implementation specifications: other requirements for contracts and other arrangements.*

(i) The contract or other arrangement between the covered entity and the business associate may permit the business associate to use the information received by the business associate in its capacity as a business associate to the covered entity, if necessary:

(A) For the proper management and administration of the business associate; or

(B) To carry out the legal responsibilities of the business associate.

(ii) The contract or other arrangement between the covered entity and the business associate may permit the business associate to disclose the information received by the business associate in its capacity as a business associate for the purposes described in paragraph (e)(4)(i) of this section, if:

(A) The disclosure is required by law; or

(B)(*1*) The business associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and

(*2*) The person notifies the business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(f)(1) *Standard: Requirements for group health plans.*

(i) Except as provided under paragraph (f)(1)(ii) or (iii) of this section or as otherwise authorized under § 164.508, a group health plan, in order to disclose protected health information to the plan sponsor or to provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO with respect to the group health plan, must ensure that the plan documents restrict uses and disclosures of such information by the plan sponsor consistent with the requirements of this subpart.

(ii) The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose summary health information to the plan sponsor, if the plan sponsor requests the summary health information for the purpose of :

(A) Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or

(B) Modifying, amending, or terminating the group health plan.

(iii) The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose to the plan sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan.

(2) *Implementation specifications: requirements for plan documents.* The plan documents of the group health plan must be amended to incorporate provisions to:

(i) Establish the permitted and required uses and disclosures of such information by the plan sponsor, provided that such permitted and required uses and disclosures may not be inconsistent with this subpart.

(ii) Provide that the group health plan will disclose protected health information to the plan sponsor only upon receipt of a certification by the plan sponsor that the plan documents have been amended to incorporate the following provisions and that the plan sponsor agrees to:

(A) Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

(B) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the group health plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

(C) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

(D) Report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(E) Make available protected health information in accordance with § 164.524;

(F) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with §164.526;

(G) Make available the information required to provide an accounting of disclosures in accordance with § 164.528;

(H) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary for purposes of determining compliance by the group health plan with this subpart;

(I) If feasible, return or destroy all protected health information received from the group health plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(J) Ensure that the adequate separation required in paragraph (f)(2)(iii) of this section is established.

(iii) Provide for adequate separation between the group health plan and the plan sponsor. The plan documents must:

(A) Describe those employees or classes of employees or other persons under the control of the plan sponsor to be given access to the protected health information to be disclosed, provided that any employee or person who receives protected health information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description;

(B) Restrict the access to and use by such employees and other persons described in paragraph (f)(2)(iii)(A) of this section to the plan administration functions that the plan sponsor performs for the group health plan; and

(C) Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph (f)(2)(iii)(A) of this section with the plan document provisions required by this paragraph.

(3) *Implementation specifications: uses and disclosures.* A group health plan may:

(i) Disclose protected health information to a plan sponsor to carry out plan administration functions that the plan sponsor performs only consistent with the provisions of paragraph (f)(2) of this section;

(ii) Not permit a health insurance issuer or HMO with respect to the group health plan to disclose protected health information to the plan sponsor except as permitted by this paragraph;

(iii) Not disclose and may not permit a health insurance issuer or HMO to disclose protected health information to a plan sponsor as otherwise permitted by this paragraph unless a statement required by § 164.520(b)(1)(iii)(C) is included in the appropriate notice; and

(iv) Not disclose protected health information to the plan sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

(g) *Standard: requirements for a covered entity with multiple covered functions.*

(1) A covered entity that performs multiple covered functions that would make the entity any combination of a health plan, a covered health care provider, and a health care clearinghouse, must comply with the standards, requirements, and implementation specifications of this subpart, as applicable to the health plan, health care provider, or health care clearinghouse covered functions performed.

(2) A covered entity that performs multiple covered functions may use or disclose the protected health information of individuals who receive the covered entity's health plan or health care provider services, but not both, only for purposes related to the appropriate function being performed.

§ 164.506 Uses and disclosures to carry out treatment, payment, or health care operations.

(a) *Standard: Permitted uses and*

COVENTRY
Health Care of Kansas, Inc.

April 4, 2003

VIA FAXSIMILE

Claudia Pemey, Rep.
KS Insurance Dept.
420 SW 9th Street
Topeka, KS 66612-1678

Consumer: Carole Ochs
Dept File # 0303CA106504
NAIC# Commercial accounts:33295489 Coventry Health Care of KS., Inc.
NAIC# PPO: 1137-81973 Coventry Life and Health Company
CHC employer group: Thayer Aerospace

Dear Ms. Pemey,

Coventry Health Care of KS., Inc. is in receipt of the above captioned consumer complaint received in our office on 3/18/03. We appreciate the opportunity to respond.

This employer group, Thayer Aerospace came to us as a fully insured group. While under the HIPAA/Health Insurance Portability Access & Accountability Act laws, we are not allowed to release individual medical claim information to a fully insured client unless we first have a signed release from each insured employee.

Without all releases, the only documentation we are allowed to provide is eggregate information which has already been supplied to Thayer Aerospace. We are enclosing a copy of the regulation that governs this ruling and highlighted the pertinent information.

not true

We cannot release the requested information without violating Federal Law.

If we may be of any further assistance, please don't hesitate to contact us.

Sincerely,

Linda Tenute

4/9/03

Linda Tenute
Director Regulatory Compliance
Coventry Health Care of KS., Inc.
lg

[816 - 941 - 3030]

Missouri Dept of Insurance Consumer Assistance 1-800-726-7390
Kansas Dept of Insurance Consumer Affairs 1-800-432-2484

HINKLE
ELKOURI
LAW FIRM L.L.C.

Reply to Main Office
Steven P. Smith
Direct fax 660-6010
ssmith@hinklaw.com

April 24, 2003

Sandy Praeger
Commissioner of Insurance
Kansas Insurance Department
420 SW 9th Street
Topeka, Kansas 66612-1678

Re: Thayer Aerospace Consolidated, LLC
– Coventry Health Care of Kansas, Inc. - Department File No. 0303CA106504

Dear Ms. Praeger:

On behalf of our client, Thayer Aerospace Consolidated, LLC, we want to express our appreciation for your prompt response to our client's letter of March 12, 2003. In that letter, our client expressed its concern that Coventry Health Care was not providing information it needed to manage its health care plan and to obtain competitive quotes from other insurance carriers. In response to our client's letter, your office contacted Coventry and obtained a written response dated April 4, 2003, which was forwarded to our client on April 8, 2003.

Unfortunately, Coventry's response does not adequately address our client's concerns. Coventry stated in its response that, under federal law, it is not allowed to release the information that our client requested unless our client first provides a signed release from each insured employee. We do not believe that this is what the federal law actually provides. Instead, we believe that Coventry has misunderstood the privacy requirements found in the HIPAA Medical Privacy Regulations (45 CFR § 160.101 et seq.).

In our view, there is nothing in the regulations that would prevent Coventry from providing the information requested by our client. In fact, we believe that our client is entitled to receive this information from Coventry so long as the conditions set forth in the regulations are met.

HIPAA MEDICAL PRIVACY REGULATIONS

The HIPAA Medical Privacy Regulations were issued in final form on December 28, 2000, and were modified on August 14, 2002. For most "covered entities," the regulations took effect on April 14, 2003. 45 CFR § 164.534. For most employer-sponsored group health plans in Kansas, however, the regulations have not yet taken effect. Under the regulations, "small health plans" are not required to comply with the regulations until April 14, 2004. 45 CFR § 164.534(b)(2). For this purpose, a "small health plan" is a plan that paid $5 million or less in annual premiums during its most recent plan year if the plan was fully-insured

or a plan that paid $5 million or less in claims during its most recent plan year if the plan was self-insured. 45 CFR § 160.103.

The basic rule set forth in the regulations is that a "covered entity" may not use or disclose an individual's "protected health information" (or "PHI") *except* as permitted by the regulations. 45 CFR § 164.502(a). The regulations then go on to set forth a number of specific situations in which PHI may be used or disclosed.

As referenced in the letter that Coventry sent to your office, PHI may be used or disclosed when an individual has signed an "authorization" permitting the use or disclosure. 45 CFR § 164.502(a)(1)(iv). This is *not*, however, the only situation in which the regulations allow PHI to be used or disclosed.

The regulations expressly allow PHI to be shared with an employer that is sponsoring a "group health plan," such as Thayer Aerospace, if certain conditions are met. The amount of PHI that may be shared and the conditions that must be satisfied before that information can be shared depend on the purpose for which the employer has requested the information.[1]

SHARING INFORMATION FOR UNDERWRITING AND/OR PLAN AMENDMENT PURPOSES

If an employer-plan sponsor requests information for the purpose of "obtaining premium bids from health plans for providing health insurance coverage under the group health plan" or for the purpose of "modifying, amending, or terminating the group health plan," a "health insurance issuer," such as Coventry, is permitted to disclose "summary health information." 45 CFR § 164.504(f)(1)(ii).

"Summary health information" is defined as information that "summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan" and from which certain identifying information has been removed. 45 CFR § 164.504(a). Although certain information must be removed before "summary health information" can be shared with an employer-plan sponsor, "summary health information," as defined in the regulations, still contains information that is detailed and useful. It is much more than the total dollar amount of claims paid. The regulations contemplate that "summary health information" will contain information about the claims incurred by *each* person covered under the plan, including type of treatment and the dollar amount of the claim, so long as the identifying information for that person has been removed.

---

[1] We would note that, although Coventry became subject to the regulations earlier this month, our client's group health plan is a "small" plan that will not be subject to the regulations until April of next year. Until the regulations do become effective as to our client's group health plan, there is nothing that would prohibit the plan from continuing to share information with our client. The fact that such information sharing may take place over the next year should not present any concerns to Coventry. Under the regulations, as modified in August 2002, the arrangement between a fully insured plan and its health insurance issuer constitutes an "organized health care arrangement" ("OHCA"). 45 CFR § 164.501. The regulations expressly provide that a "covered entity" that participates in an OHCA "may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement." 45 CFR § 164.506(c)(5). Thus, Coventry is expressly permitted to share PHI with our client's plan without regard to the fact that our client's plan will not be required to comply with the regulations until April of next year.

There are no other conditions that must be met if an employer wants to receive "summary health information" for underwriting purposes or for purposes of considering a change in the benefits that are being offered. If an employer is sponsoring a "group health plan" and the employer requests "summary health information" for either of these two purposes, that information may be shared.

SHARING INFORMATION FOR PLAN ADMINISTRATION PURPOSES

A "health insurance issuer" is also permitted to disclose PHI if an employer-plan sponsor requests that information in order to perform "plan administration functions" and if certain conditions are met. 45 CFR § 164.504(f)(3).

"Plan administration functions" are defined as follows:

> *Plan administration functions* means administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

45 CFR § 164.504(a). As examples of "plan administration functions," the preamble to the regulations lists such activities as quality assurance, claims processing, auditing, monitoring, and the management of carve-out plans, such as vision and dental. 65 Fed. Reg. at 82508 (Dec. 28, 2000).

As a condition of receiving PHI in order to perform a "plan administration function," an employer-plan sponsor must amend the plan document to include specific provisions relating to the use and disclosure of any PHI that the employer receives. Among other things, the amendments must describe the employees who are allowed to receive the information, must restrict access and use of the PHI to those employees, and must provide "an effective mechanism for resolving any issues of noncompliance" by such employees. Additionally, the employer must certify that the plan document has been amended and that it agrees to the restrictions set forth in the amendments. 45 CFR § 164.504(f)(3).

If these conditions are met, the employer is entitled to receive PHI from the plan and from the plan's "health insurance issuer."

REASONS AN EMPLOYER MIGHT WANT TO RECEIVE PHI FROM A HEALTH INSURANCE ISSUER

Given fiduciary responsibilities that an employer has under ERISA with respect to the operation of its "employee welfare benefit plans," it is our expectation that many employers, particularly larger employers, will feel that they need to receive PHI in order to ensure that their plan is being administered according to the terms and conditions of the plan document. In particular, we expect that many employers will want to receive PHI in order to ensure that claims are being correctly processed.

Although most insurance carriers are diligent about processing claims, there are times when the employer may be in a better position than the insurance carrier to flag claims that are not properly payable by the employer's plan. Consider, for example, the following situations:

(1) **Coordination of Benefits.** There are times when a claim should be paid by someone other than the employer's group health. For example, if a covered employee is injured while at work, the claim may be one that should have been paid through the worker's compensation system rather than under the group health plan. The employer will ordinarily be aware of injuries that are job-related and is therefore in a good position to detect claims that should be routed through the worker's compensation system. The insurance carrier for the plan, on the other hand, will not necessarily know that a particular claim is arising out of a work-related injury.

(2) **Person is Not Covered Under the Plan.** There are times when a claim is incurred for a person who is not covered under the plan. For example, it may be that the person is no longer part of the group. This could include a person who is no longer employed by the employer and who did not elect COBRA. It could also include a divorced spouse who is still being covered as a dependent (rather than as a COBRA beneficiary) because the employee failed to inform the group health plan of the divorce. Or, it could be a situation in which the person was never part of the group but the claim was posted to the group by mistake. An employer will frequently be in a better position than an insurance carrier to identify such claims.

(3) **Benefits are Not Payable Under the Plan.** It sometimes happens that a claim is filed for a benefit that is not provided by the plan. Although one would generally expect an insurance company to know what benefits are payable and what are not, mistakes may happen. If the employer does not receive detailed information about the claims that have been paid, it is possible that a mistake of this type would never be caught.

CONCLUSION

To say that the HIPAA Medical Privacy Regulations "prevent" a health insurance issuer, such as Coventry, from sharing information with an employer-plan sponsor, such as Thayer Aerospace, is wrong. There is nothing in the regulations that prohibits an employer from receiving information if that information is needed for a legitimate purpose and if the employer has satisfied the conditions, if any, that regulations impose for receiving information for that purpose.

Employers have the responsibility to obtain coverage for their group health plans and to ensure that those plans are being administered correctly according to their terms. To carry out this responsibility, they need to receive information from their health insurance issuer.

For their part, health insurance issuers have a responsibility to read the regulations carefully and in light of their stated purpose. The regulations were not intended to cut off the flow of information between an employer and a health insurance issuer and they were not intended to remove the employer from any type of oversight role for its group health plan.

If an insurance company wants to say that, "because" of the regulations, it will no longer share any amount of meaningful information with an employer, that insurance company is really saying that it is not willing to put forth the effort that is required to read and understand the regulations to which it is subject. In a health care system in which we are all dependent, to some extent, upon others, this abdication of responsibility cannot be excused. If the insurance companies are not willing to share information with employers, the system will not work. Costs will increase, employers will reduce the benefits they are offering, and employees and their families will lose out.

We would respectfully submit that your office should look into this situation and that it should encourage, and even prod, the insurance companies it regulates to cooperate with employers in sharing the information that employers need to obtain coverage and to oversee the operation of their group health plans.

We appreciate the attention you have already paid to this matter and look forward to working with your office to resolve these concerns in a way that will be beneficial for everyone concerned. If you have any questions about any of the matters discussed in this letter or about the HIPAA Medical Privacy Regulations as they affect employers, please do not hesitate to contact our office.

Sincerely,

HINKLE ELKOURI LAW FIRM L.L.C.

Steven P. Smith

Enclosures
cc: Carole Ochs, Vice President Human Resources, Thayer Aerospace Consolidated, LLC
Buz Lukens, IMA
Karen Cox, IMA

FRIENDS UNIVERSITY
1898 CENTENNIAL 1998

February 17, 2004

To: Members of the Insurance Committee

From: Kelley Dawson, Associate Vice President, Administration & Finance

The basis of my testimony is the attached documentation of the conversations and correspondence between IMA, our insurance broker, Blue Cross Blue Shield, and me. As you can see, even though we were willing to fund their cost for providing additional data, Blue Cross refused on the basis of HIPAA. HIPAA does not require that insurers deny the information only that agreements are in place to ensure the privacy of the information. We and our broker, IMA, can ensure that privacy. It is apparent to us that Blue Cross is really not interested in working with employers to provide meaningful information to assist in providing health care coverage to their employees at reasonable costs.

I urge you to pass House Bill No. 2689. The remedy it will provide to employers is desperately needed in order to continue to provide health care coverage to their employees.

Kelley Dawson

House Insurance
Date: 2/17/04
Attachment # 11

2100 W. University St.
Wichita, KS 67213-3397
(316) 295-5000

INSURANCE MANAGEMENT ASSOCIATES, INC.

Memorandum

DATE: June 17, 2003

TO: Eric Namee, Steven Smith – Hinkle Elkouri
SueAnn Schultz, Alisha Bond, Dyan Thornton – IMA
Renee Kuhs - Zywave

FROM: Karen S. Cox

RE: DMW Data Request from Friends University to BCBS of KS

I believe you all are familiar with the request for DMW data for Friend's University. If not, I have attached the original e-mails going back and forth from IMA and Blue Cross and Blue Shield.

Decision Master Warehouse (DMW) is a high-tech, detailed claims analysis IMA provides for our larger clients. This report is prepared from claims data that is provided by the client's insurance carrier or administrator. This report is state-of-the-art technology that provides us and the client with a wealth of knowledge regarding the group's own claims utilization, enabling us to make management decisions that will help to manage the risk and ultimately contain costs. BCBS charges the client $3,000 for this one-time data dump. No one else in the entire country charges that much for a group's own claims utilization data. BCBS has provided this information twice to one of my self-funded accounts and once to another.

Upon requesting the same information for Friend's University, we received the first e-mail response dated 5/8/2003 denying this request, citing HIPAA. After my rebuttal, I got the response on same date saying that although the data is scrambled, information could still be tied back to specific individuals. I received no response after my second rebuttal.

Renee Kuhs, attorney for Zywave, then provided us with the letter we sent to Mark Dolsky on June 4th. We then received the letter (no date) but date stamped 6/11/03, which cites new reasons why they won't provide this information.

I find this unacceptable and would welcome thoughts on how to proceed next.

P.O. Box 2992
600 IMA Plaza
250 North Water
Wichita, Kansas 67201-2992

316-267-9221
Facsimile 316-266-6342

Cox, Karen

From: Cox, Karen
Sent: Tuesday, June 17, 2003 3:04 PM
To: Bond, Alisha
Subject: FW: FW: Zywave Reports

FYI.

-----Original Message-----
From: Cox, Karen
Sent: Friday, May 09, 2003 8:12 AM
To: 'Mark.Dolsky@bcbsks.com'
Cc: Bond, Alisha; 'kathy@friends.edu'; 'Bernardo.Cruz@bcbsks.com'; Schultz, SueAnn
Subject: RE: FW: Zywave Reports

That is just not true. There is no way this report can identify individuals. Even if it did, Friends University's compliance date for HIPAA
isn't until April 14, 2004. They can receive any and all PHI without complying to HIPAA until that date. The inability for Friend's to receive
this information will cripple their efforts to effectively manage their risks and costs and ultimately your rates!

Karen S. Cox, CHC
Vice President - Employee Benefits
IMA of Kansas
316-266-6300; Fax 316-266-6342
email: karen.cox@imacorp.com
home page: http://www.imacorp.com

-----Original Message-----
From: Mark.Dolsky@bcbsks.com [mailto:Mark.Dolsky@bcbsks.com]
Sent: Thursday, May 08, 2003 4:55 PM
To: Cox, Karen
Cc: Bond, Alisha; 'Bernardo.Cruz@bcbsks.com'; 'kathyb@friends.edu'
Subject: Re: FW: Zywave Reports

Karen, I appreciate your response on our denial of the Zywave request for
Friends University. However, since Friends University is fully insured
BCBSK will not be providing the information you have requested in the file
layout. Although this layout scrambles some of the information, the account is small enough that the information could be tied back to specific
individuals within the group due to items such as Claimant sex, age, place
of service, etc. We don't supply this type of information on any of our
fully insured accounts. Only total claims summary information is available. We will be sending the check back to you.

"Cox, Karen"

11-3

<karen.cox@imacor p.com>

To: "'Mark.Dolsky@bcbsks.com'" <Mark.Dolsky@bcbsks.com>

cc: "Bond, Alisha" <alisha.bond@imacorp.com>, "'kathyb@friends.edu'" <kathyb@friends.edu>,

05/08/2003 04:05 PM

"'Bernardo.Cruz@bcbsks.com'" <Bernardo.Cruz@bcbsks.com>

Topic:

Subject: FW: Zywave Reports

Mark, we received this response to Friend University's request for claims data for the Decision Master Warehouse Claims Utilization Management Report.
There must be some misunderstanding of the request in that the response for not being able to comply is not appropriate for two reasons. First of all, there is no PHI included in this data request. Secondly, under HIPAA, there is no regulation that says fully insured groups are not entitled to detailed PHI. However, that isn't even relevant since we're not asking for PHI.

So, please keep the check and proceed with this request. If I can provide you with any clarification on the above, please let me know.

Karen S. Cox, CHC
Vice President - Employee Benefits
IMA of Kansas
316-266-6300; Fax 316-266-6342
email: karen.cox@imacorp.com
home page: http://www.imacorp.com

-----Original Message-----
From: Bernardo.Cruz@bcbsks.com [mailto:Bernardo.Cruz@bcbsks.com]
Sent: Thursday, May 08, 2003 9:49 AM
To: alisha.bond@imacorp.com
Subject: Zywave Reports

We reviewed your recent request for the Zywave reports and determined we would not be able to comply. Fully insured groups are not entitled, under HIPAA, to receive the detailed PHI that would be included in this report.
I will return your request and check today. Let me know if you have any questions. Thanks.

11-4

the
sole use of the intended recipient(s) and may contain proprietary, confidential, trade secret or privileged information. Any unauthorized review, use, disclosure or distribution is prohibited and may be a violation of law. If you are not the intended recipient or a person responsible for delivering this message to an intended recipient, please contact the sender by reply email and destroy all copies of the original message.

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11-5

IMA

June 4, 2003

Mark Dolsky
Regional Manager
Blue Cross/Blue Shield
257 N. Broadway
Wichita, KS 67202

RE: Friends University Data Request

Dear Mark,

On April 29, 2003 we requested Decision Master Warehouse (DMW) data elements for Friends University. Our original request for claims data made on behalf of Friends University was declined based upon the HIPAA Privacy Rules which govern the use and disclosure of protected health information. While the HIPAA Privacy Rules regulate the use and disclosure of PHI, the rules also allow a health plan to share protected health information with a third party for purposes of data analysis where a business associate contract is in place. We respectfully request that Blue Cross Blue Shield of Kansas enter into a business associate contract with Zywave, the company that creates DMW analysis, in order that we may continue to make available our data analysis tools to our mutual client, Friends University.

You may contact Renee Kuhs, Employee Benefits Attorney and HIPAA Project Leader, at Zywave to discuss further Zywave's HIPAA compliance efforts. Zywave is more than willing to enter into a mutually acceptable business associate contract and indemnify Blue Cross Blue Shield of Kansas.

I thank you in advance for your consideration of our request. Please contact me at your earliest convenience to provide direction on how you wish to proceed.

Sincerely,

Karen Cox
VP Employee Benefits, IMA

Cc: Kathy Burnett, Friends University

11-6

BlueCross BlueShield of Kansas*
Premier Blue
www.bcbsks.com

Customer Service in Topeka
(800) 432-3990
Fax (785) 290-0711
E-mail: csc@bcbsks.com

Premier Blue
In Kansas (800) 552-0028
In Topeka or out of state (785) 291-4010
257 N. Broadway
Wichita, Kansas 67202-2317

Professional Relations
(316) 269-1674
Fax (316) 269-1695

Marketing
(316) 269-1666
Fax (785) 290-0752
(800) 432-0216

Karen Cox
VP Employee Benefits, IMA
600 IMA Plaza, 250 N. Water
P.O. Box 2992
Wichita Ks 67201

RE: Friends University Data Request

Dear Karen:

I received your letter on June 6th, 2003, asking Blue Cross Blue Shield of Kansas (BCBSKS), to enter into a business associate contract with Zywave. This request is in reference to the denial of the DMW data elements for Friends University.

BCBSKS will not enter into a business associate contract with Zywave. Our reasons are simple. The Zywave report requests proprietary information that we won't provide, regardless of HIPAA issues. In addition, we have spent numerous hours in developing our new reporting system, COGNOS, for larger accounts. This system was created using a focus study group that included the interaction of several large enrolled groups.

The study concluded that accounts want a concise utilization format. The new COGNOS format provides the information in the format recommended by the focus study group. It supplies the client with detailed information that can be used to provide direction in benefit design structure. Large enrolled groups will receive this report each year at renewal without any additional charges plus the 'patient expense summary report'. In addition they can receive other reports that do not include 'personal health information', for a small charge.

We provide all of our clients with the necessary claims and utilization information needed to make an informed and educated decision about their health insurance plan. We would be happy to go over the information we provide for Friends University.

Thank you for your time and commitment to our mutual client Friends University. Please contact me if you have any questions.

Sincerely,

Mark Dolsky

Mark Dolsky
Regional Marketing Manager, BCBSKS

Cc: Joe DeWerff, BCBSKS
Treena Mason, BCBSKS
Doug Marten, BCBSKS
Bernardo Cruz, BCBSKS

Examples of Claims Reporting Issues Experienced by Friends University

IMA has provided our clients with a detailed claims utilization management report called Decision Master Warehouse. We pay for this report and provide it to our clients as a risk management service. We have to rely on the insurance carrier/administrator to provide an extract of twelve months of paid claims as per the Data Requirements attached. BCBS started out charging the client $2,000 for this extract, then went to $3,000 and now says they can't have it, first citing HIPAA and saying that it is proprietary. This report is being provided to thousands of employers by numerous agencies across the country. No other insurance carrier nationally has charged this much for group's own claims data. And now, it is no longer available. This report is a highly sophisticated claims analysis tool that allows the employer to slice and dice their data no less than a million different ways to determine where their risk lies. It also has a benefit-modeling feature that allows them to analyze benefit changes and the resulting savings. BCBS does not provide anything like this and should not feel threatened by this because it only helps the employer analyze his or her own data.

Friends also was denied detailed claims experience when they received their renewal. They had always received this in the past.

Friends then asked for a deductible report, which is traditionally provided for a $100 charge. Friends wanted to use this report to help analyze an increase in deductible. BCBS denied this request. However, this is the same report that groups have to have when they leave BCBS and they need to get deductible credits with the new, incoming carrier. We were told that if Friends was leaving they could get this report!?!

In the past month, we have ordered this deductible report for one group below 50 in size who has left BCBS and are now told they cannot have it. Apparently, groups over 50 can have it (if they leave). BCBS is making it difficult for the small groups to leave and penalizing the employees by not giving them the tools to get their deductible credits. They were told the only way to get the information was to have every employee call in to customer service and order their own personal EOBs. This is a big change in their policies and procedures and we're not sure why.

Kansas Insurance Department

Sandy Praeger COMMISSIONER OF INSURANCE

October 1, 2003

Kelley Dawson
Associate Vice President, Administration & Finance
Friends University
2100 W. University Street
Wichita, Kansas 67213-3397

Re: Claims History Information Under HIPAA Privacy Rules

Dear Mr Dawson:

Thank you for bringing to our attention your experience with Blue Cross Blue Shield of Kansas. Like employers, benefit plan administrators, and insurance companies, the Kansas Insurance Department (KID) is still assessing the full impact of the HIPAA privacy regulations. KID has received a number of similar complaints, involving several insurance companies, and is in the process of drafting a directive.

We agree that HIPAA should not be misused as an "excuse" to withhold information, but acknowledge that it may be a legitimate *reason* for an insurer to withhold detailed claims history information. HIPAA privacy regulations are strict and complicated

The HIPAA rules permits insurers to disclose full claims history if employees give consent. Some authorities suggest that an employer or employee welfare plan should ask group members to submit individual claims history directly to potential insurers in order to obtain a bid for group coverage.

In general, however, only summary health information may be disclosed without consent. The data must be de-identified as prescribed by C.F.R. 164.514(b). This leaves some room for the application of judgment, so some disagreement over the precise level of specificity allowable is to be expected

The authority to interpret and enforce the HIPAA privacy rules rests with the Secretary of Health and Human Services (H&HS). However, KID takes the position that, in the

420 SW 9TH STREET
TOPEKA, KANSAS 66612-1678

PHONE 785.296.3071
FAX 785 296 7805

CONSUMER HOTLINE
1 800.432 2484

WEBSITE
www.ksinsurance org

interest of fair competition and protection of the public welfare, insurers should provide information in accordance with industry practice or contractual agreement unless precluded by a good faith interpretation of HIPAA privacy rules or in reliance upon an opinion issued by the Secretary of H&HS.

Sincerely,

John W. Campbell
General Counsel

FRIENDS UNIVERSITY

September 4, 2003

Sandy Praeger
Commissioner of Insurance
Kansas Insurance Department
420 SW 9th St
Topeka KS 66612-1678

Dear Commissioner Praeger

We at Friends University, like most employers, have been very concerned with our rising health plan costs. We feel an obligation to our employees to do the best possible job to monitor these costs and continue to provide them with comprehensive and affordable health care benefits

We have a fully insured plan with Blue Cross and Blue Shield of Kansas. We have made several attempts to obtain claims utilization to assist us in managing our costs and making important plan design changes We have even agreed to pay the fee that BCBS charges for this information. We have repeatedly received conflicting reasons as to why we cannot get this information, even though it has been available in the past.

We originally we requested an electronic data file of our claims utilization as specified in the attached. We wanted this information so our broker could provide us with the Decision Master Warehouse Claims Utilization Management Report that would enable us to determine the root causes of our medical cost and utilization trends, compare our claims experience to industry and geographic benchmarks and to focus on solutions. We sent a check for $3,000, which was BCBS's charge for such data We were then told that BCBS could not provide this data because "fully insured groups are not entitled, under HIPAA, to receive the detailed PHI, that would be included in this report". Our check was returned. We then wrote a letter (attached) and appealed to Mr Michael Mattox, President of BCBS. A response was received from Andrew Corbin (also attached), which in addition to HIPAA, cites the fact that this information is proprietary to BCBS He also indicated the report is expensive to produce

We disagree that our own claims data is proprietary and feel that $3,000 is more than adequate to pay for the expense of providing this report. BCBS has already provided this report to other groups at this cost. Thousands of employers across the country have been able to get this information from most insurance carriers at either little or no cost In addition, as you will see from the attached list, the claims utilization is not identifiable

We have always received detailed claims experience at our renewal. This year, however, this was not provided citing HIPAA as the excuse and we were unable to verify the accuracy of our claims data or properly assess our risk

We then asked for a report, which would provide us with the amounts each employee has met towards their deductible This report would have been used to help us assess the effect of increasing our plan deductible. We were told this report was available for a $100 charge. We then received the attached letter dated 7/29/03 from Bernardo Cruz, which says that due to HIPAA, this information could not be provided Again, HIPAA does not say that. But, what is even more confusing, this report is a necessity when an employer changes carriers and needs to obtain deductible credit so employees are not penalized during the move. As we understand it, we would be able to receive this information from BCBS if we were making a change in carriers

2100 W. University St.
Wichita, KS 67213-3397
(316) 295-5000

We are frustrated and concerned. We are desperately trying to maintain a cost effective health plan for our employees To do so, we need our insurance carrier to help us, not tie our hands

Sincerely yours,

Kelley Dawson

Kelley Dawson
Assoc. Vice President, Administration & Finance

Attachments

Medical Claim Data Requirements

for Decision Master® Warehouse

Following is a set of guidelines and data element requirements necessary for analyses performed by Zywave, Inc. Please submit data and supporting documentation to:

Attn.: John Grant
2323 N. Mayfair Road, Suite 320
Milwaukee, WI 53226
414.475.1591 Fax 414.475.7636
e-mail: john.grant@haack.com

General Requirements

1) Please provide claim data for all medical claims processed during the reporting period specified
2) Please provide the data elements listed below for each medical claim reported
3) Please include a variable which differentiates employees from dependents and dependents from each other (i e , claimant relationship code or member code)
4) Please include a variable which differentiates active employees from Medicare-eligible group retirees (if applicable)
5) Please provide data via diskette or CD in a fixed-length, ASCII format. Please include a record layout which indicates field length and field format.
6) Please provide employee coverage counts (single/dependent/family) and fixed expenses (i e fees for administration, U M , PPO, Stop Loss etc) for the reporting period specified

Specific Data Element Requirements

a) Unique Scrambled Identification Number for each Employee (ie scrambled SSN)
b) Employee Status - see (4) above
c) Claimant Relationship Code - see (3) above *
d) Claimant Sex
e) Age of Claimant
f) Place of Service *
g) Type of Service *
h) ICD-9 Diagnosis Code
i) CPT Procedure Code
j) Benefit/Service Code *
k) Provider Identification Number (federal tax ID if available) (May be scrambled)**
l) Provider Name
m) Provider Type *
n) PPO Provider Indicator
o) Date(s) of Service (both from and through dates)
p) Paid Date (date processed)
q) Total Charged Amount
r) Total Paid Amount

* Please provide a list of valid codes and definitions
** Each provider must have a unique scrambled ID number

Layout of Sample File Data*

Field	Start	Width**
Patient ID***	1	16
Group	17	4
Relation(ship)****	21	4
Sex	25	2
Age of Claimant	27	9
Place of Service (POS)****	36	2
Type of Service (TOS)****	38	4
Diagnostic Code (ICD-9)	42	6
CPT Code (CPT4)	48	6
Benefit/Service Code*****	54	3
Provider Tax ID	57	10
Provider Name	67	35
Provider Type*****	102	4
PPO Flag	106	2
From Date	108	9
Through Date	117	9
Process Date (Paid Date)	126	9
Total Charges	135	20
Total Paid Amount	175	20

Include the following information if available:
Ineligible Amount ($)
Ineligible Reason Code*****

---

* This is the layout for the sample fixed length file enclosed

** The width of your fields may vary from the sample

*** For confidentiality purposes, we strongly encourage you to provide a scrambled employee ID number However, each employee must have a unique ID number and that number must identify any claims related to that employee

**** Please provide a list of valid codes and definitions

Cox, Karen

From: Cox, Karen
Sent: Thursday, May 08, 2003 4:06 PM
To: 'Mark Dolsky@bcbsks.com'
Cc: Bond, Alisha; 'kathyb@friends.edu'; 'Bernardo Cruz@bcbsks.com'
Subject: FW: Zywave Reports

Mark, we received this response to Friend University's request for claims data for the Decision Master Warehouse Claims Utilization Management Report. There must be some misunderstanding of the request in that the response for not being able to comply is not appropriate for two reasons. First of all, there is no PHI included in this data request Secondly, under HIPAA, there is no regulation that says fully insured groups are not entitled to detailed PHI However, that isn't even relevant since we're not asking for PHI.

So, please keep the check and proceed with this request If I can provide you with any clarification on the above, please let me know

Karen S. Cox, CHC
Vice President - Employee Benefits
IMA of Kansas
316-266-6300; Fax 316-266-6342
email: karen.cox@imacorp.com
home page: http://www imacorp.com

-----Original Message-----
From: Bernardo.Cruz@bcbsks.com [mailto:Bernardo.Cruz@bcbsks com]
Sent: Thursday, May 08, 2003 9:49 AM
To: alisha.bond@imacorp.com
Subject: Zywave Reports

We reviewed your recent request for the Zywave reports and determined we would not be able to comply. Fully insured groups are not entitled, under HIPAA, to receive the detailed PHI that would be included in this report. I will return your request and check today. Let me know if you have any questions Thanks.

11-15

July 8, 2003

Mr. Michael Mattox
President
Blue Cross Blue Shield
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Dear Mr. Mattox;

I am writing in regards to your recent decision to withhold claims data we requested for the Decision Master Warehouse claims utilization analysis tool that is available through our broker, IMA. After numerous emails between IMA and Blue Cross in Wichita, I decided to call Mark Dolski. He explained that it was a corporate decision (not HIPPA restricted as first suggested) and that you have not provided this data to any clients – self-insured or fully-insured for some time. I understand from IMA that you provided this information to a self-insured client in the same month you withheld our data, May 2003. This being the case, I again request the data as soon as possible.

As you are no doubt aware, providing health insurance to employees has become increasingly expensive. We are a non-profit, higher-educational institution and have always strived to provide the best for our employees. We are having a difficult time absorbing repeated large premium increases. At the same time, we find it difficult to pass on the large increases to our employees, who, since we are non-profit, are not earning large salaries. When IMA approached us with a tool that would enable us to perform alternative modeling and provide information on our usage patterns, we were very excited. This tool will allow us to make changes that would save the most dollars impacting the least users. I am sure you can appreciate that objective.

Our renewal date is October 1, 2003, so time is of the essence for receiving the data. If you would like to discuss further you may contact me per below.

Sincerely

Kelley Dawson, SPHR
Associate Vice President, Administration & Finance
Friends University
316-295-5894 office
316-644-2634 cell
316-295-5010 fax

11-16

BlueCross BlueShield of Kansas

1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

In Topeka - (785) 291-7000
In Kansas - (800) 432-0216

Web site: www.bcbsks.com

July 22, 2003

Ms. Kelley Dawson, SPHR
Associate Vice President, Administration & Finance
Friends University
2100 W. University St.
Wichita, KS 67213-3397

Dear Ms. Dawson:

Mike Mattox forwarded your letter to me for a response dealing with concerns about receipt of claims information for Friends University. You requested IMA to ask Blue Cross and Blue Shield of Kansas for specific claims information on your account. This information was requested by IMA to Blue Cross and Blue Shield of Kansas to be supplied in an electronic claims format to Zywave, using the Data Master Warehouse data elements. IMA had already been notified that we would not supply the Zywave information.

The information elements of this data request contain personal health information (PHI) of individuals enrolled in Friends University group health plan. The Health Insurance Portability and Accountability Act (HIPAA) does not allow us to release information that contains PHI on fully insured groups with over $5,000,000 in annualized claims after April 14, 2003. Although Friends University does not meet this criteria, and would not be subject to this requirement until April 14, 2004, Blue Cross and Blue Shield of Kansas made a corporate decision to provide the same claims data to all fully insured groups as of April 14, 2003.

The Zywave report also requests information that is proprietary to Blue Cross and Blue Shield of Kansas. We made the decision to discontinue supplying this information to any self-funded or fully insured accounts. These reports are expensive to produce and as has been indicated, there are few changes based on diagnostic conditions that could be made. Rather than debating the value of Zywave with IMA, we have told them we won't provide this information.

Health insurance utilization patterns are increasing and we realize that having access to claims information will assist you in making benefit design modifications. We will provide you a claims utilization report that will review two twelve-month benefit periods to assist you during your health renewal. This report provides the necessary details to make decisions on hospital and professional claims usage patterns within your group without supplying any PHI or proprietary information.

The report has been sent to Bernardo Cruz, the Blue Cross and Blue Shield of Kansas representative for Friends University. He will meet with you to review the claims utilization information.

Respectfully,

Andrew C. Corbin
Vice President, Marketing,
Provider Relations & Reimbursement
Office: 785-291-8733
Fax: 785-291-8997
e-mail: andy.corbin@bcbsks.com

ACidd

cc: Mike Mattox
President & CEO

cc: Joe DeWerff
Director, External Sales

cc: Mark Dolsky
Regional Manager, Wichita

cc: Bernardo Cruz
Senior Group Consultant, Wichita

BlueCross BlueShield of Kansas
Premier Blue
www.bcbsks.com

Customer Service in Topeka
(800) 432-3990
Fax (785) 290-0711
E-mail: csc@bcbsks.com

Premier Blue
In Kansas (800) 332-0028
In Topeka or out of state (785) 291-4010

257 N. Broadway
Wichita, Kansas 67202-2317

Professional Relations
(316) 269-1674
Fax (316) 269-1695

Marketing
(316) 269-1666
Fax (785) 290-0752
(800) 432-0216

July 29, 2003

Ms. Kathy Burnett
Friends University
2100 W. University
Wichita, Ks. 67213

RE: Deductible and Coinsurance Report

Dear Kathy,

In reference to the report requested, we are unable to provide this information in its current format. Please find enclosed your check for $100.

The requirements and complexities of HIPAA have limited many of the rights to information that clients were entitled to procure. Our company has positioned itself to be in compliance and therefore reduced the availability and exchange of data containing personal health information.

Please contact me if you have any questions or need further information.

Respectfully,

Bernardo Cruz
Senior Group Consultant
Blue Cross Blue Shield of Kansas

/ljj

11-19

Kansas Committee on Insurance Hearing

Proposed House Bill No. 2689

Testimony by Gary S. Endicott
Chief Financial Officer for Leisure Hotel Corporation and
Board Treasurer for Kansas Children's Service League

Introduction:

My name is Gary Endicott and I am the Chief Financial Officer for Leisure Hotel Corporation including its subsidiaries and affiliates (hereinafter referred to as "Leisure"). Leisure is in the business of managing hotels and restaurants; development of hotels and restaurants; construction and project management of hotels and restaurants; and commercial real estate brokerage. Leisure's corporate offices were located in Hutchinson, Kansas until the majority of the corporate group was relocated to Leawood, Kansas in Johnson County in April 2003. Leisure is the largest hotel operator within the State of Kansas located in all geographic regions and has over 300 employees eligible for health insurance within Kansas plus over 300 additional employees eligible for health insurance outside of the State of Kansas.

I also serve as Treasurer for the Board of Directors of the Kansas Children's Service League ("KCSL") which administers all adoption contracts within the State, in addition to all foster care for Region 3, under contract with the State of Kansas. KCSL has over 400 employees in all geographic regions within the State who are eligible for health insurance.

Health Insurance Experience by Leisure:

Leisure had primary medical insurance coverage for part of their employment base with Blue Cross / Blue Shield of Kansas during FY2001 and FY2002 and moved its

primary plan to Blue Cross / Blue Shield of Kansas City in April 2003 when their corporate office was relocated to Johnson County. Leisure also provides health insurance coverage with Foundation One of American Fidelity Assurance Company for the remainder of their employment base since FY2000. Leisure's medical premiums with Blue Cross / Blue Shield of Kansas increased in excess of 30% after our first anniversary date and increased in excess of 60% after our second anniversary date when we moved our insurance coverage to Blue Cross / Blue Shield of Kansas City when the corporate offices were moved to Johnson County. This increase was in addition to significantly scaling back benefits to employees. We were facing double digit increases with Blue Cross / Blue Shield of Kansas City until our insurance agent managed to reclassify our group under a special one-time exception that kept our increases to single digits with further scaling back of benefits to employees.

Due to skyrocketing medical costs, we have tried to educate our employees on how to purchase medical/prescription services and change their behavior to keep annual increases manageable. Unfortunately, we (as employer) have been unable to obtain information from our insurance company to aide us in the process. Additionally, we have requested information from both Blue Cross / Blue Shield of Kansas and Blue Cross / Blue Shield of Kansas City to facilitate our annual insurance renewals and were refused information related to our requests. This forces our company to obtain detailed medical questionnaires from all eligible employees each year that must be fully completed and returned within a very short period of time. This process has been highly disruptive to business operations and puts employee health information at risk of getting into the hands of those outside of the "need-to-know" process due to our operations being in multiple

locations around the State. The questionnaire process is also exasperated due to our employment base consisting of several Spanish speaking personnel requiring other bi-lingual personnel to assist them during the renewal process since such information is not available directly from the insurance company. Additionally, the insurance underwriting process is more lengthy and we generally only have a few days from our renewal date to make alternative decisions which leaves us with few choices. We have communicated to our employees that we may have to terminate medical insurance coverage altogether if medical costs continue to rise at their current rate. Unless there are substantive changes in the way claims history information is provided, this will likely become reality within the next one or two years for our company.

Health Insurance Experience by KCSL:

Joe Whitaker, Chief Financial Officer for KCSL, ("Whitaker"), is primarily responsible for managing the financial affairs of KCSL that includes health insurance. I personally met with Whitaker during KCSL's health insurance renewal process and afterwards. KCSL previously had coverage with Blue Cross / Blue Shield of Kansas and was forced to change providers due to lack of information for which to make an informed decision. Whitaker expressed several similar frustrations to that of Leisure due to lack of critical information from their insurer. Additionally, Whitaker indicated that to the extent KCSL's insurance provider was willing to provide information, there were hefty fees assessed. KCSL has two primary reasons for obtaining information from their medical insurance provider: 1) to obtain information that will allow KCSL to better educate employees on how to reduce medical costs, and 2) to obtain it's own claims history information that will allow KCSL to obtain competitive quotes from several insurance

companies to minimize insurance premium increases for Kansas employees. Accordingly, KCSL changed insurance providers paying higher costs in order to obtain better information. Although KCSL does not know whether their change was the best choice, they hope it will help the process in future years.

Summary:

Medical costs are spiraling out of control throughout our country and within our State. Insurance companies are an integral part of the medical industry. Due to their ability to squelch the flow of information, they are in a position to keep medical premiums higher and the citizens of Kansas have no way of judging the reasonableness of such increases. This creates an atmosphere of anti-competitiveness and will force hundreds of employers to drop insurance coverage altogether. I hereby urge the passage of House Bill No. 2689.

House Bill No. 2689

Good afternoon. I am Kevin Regier, Assistant Controller with BEREXCO, Inc.. I am here in support of House Bill No. 2689.

The information we are trying to have made available to us is vital to our business as we try to control and manage our Insurance costs. As an example, the last year we received a Patient expense summary were for claims dated 6-1-2001 to 5-31-2002 and our claims were $257,064. Of this amount, with the summary in hand, we were able to determine that 23% of these claims were to one person, who had become very ill and subsequently passed away in 10-2001. We also determined that a total of 44% came from a total of 4 claims. BEREXCO has 40% credibility factor, so 40% of our rate is determined by last year's claims. So with this information in hand, we were at least able to have some of the relevant facts as we discussed our renewal rate. In fact, all 4 of these claims were completely paid out. They were all very freak occurrences and unlikely to happen again. So when we were negotiating for our next policy period we had this information to bring to the table.

This current year, when we asked for the claims history for our 10-1-2003 renewal, our Blue Cross representative Kathy Hanson told us that they could not give out this information because of the new HIPPA laws. Our representative knew the HIPPA laws and she adamantly argued that all we needed to do was certify that we were compliant and this information should be made available to us. After talking with a supervisor Kathy Hanson then told our representative that it was Blue Cross's policy not to provide this information. So had we not known the law, BC/BS would have cited HIPPA law as the reason not to provide this information, but since we knew the law it was now company policy not to give this information.

BEREXCO is an oil and gas business and have many vendors that we pay. Not 1 other vendor is allowed **NOT** to give us detail for purchases they are charging us for. We have a responsibility to interest owner of the leases we operate to control and manage costs. Our employee's pay 40% of the premium dollars and we have a responsibility to them to get the best rates as possible. This information, the bill would require be provided, is necessary for us to be responsible to the employees of BEREXCO and the owners of BEREXCO operated properties.

BEREXCO went self funded this year **SOLELY** so we could monitor and produce the information that should be provided in the first place. Our representative now enters into a database each week claim costs by individual, so at the end of the year we will have this information. First, to verify that Blue Cross made no mistakes in paying claims on people who shouldn't be covered. Second, now BEREXCO will have the necessary information to market our insurance needs to obtain the best value for the company and our employees. **This is the REAL reason, I believe, this information is not being made available.** A claims history report is of utmost importance in marketing insurance needs.

I have in my hand the current Wichta Business Journal where Blue Cross is quoted "I think the strongest thing to iterate here ... is that no one seems to have trouble with what's being made available now." Graham Bailey BC/BS. The next paragraph says "The city of Hays terminated its contract in part because they could not get claims history information." I know for a fact the person who negotiates our insurance contract was mad enough to yell at our BC/BS representative over this very matter.

The very fact I am here in support of a bill designed to require providers to provide this information **DOES NOT** sound like "no one seems to have trouble with what's being made available now." This information **is important** for our business to have and also important for the many other businesses of Kansas.

Fiserv Health - Kansas

Phone: (316) 264-5311
Fax: (316) 264-8077

300 West Douglas
Suite 800
PO Box 2697
Wichita, KS 67201-2697

Fiserv Health™

Testimony before the House Insurance Committee on February 17, 2004
Reference HB 2689

1. **Madam Chairwoman and members of the committee, I very much appreciate the opportunity to provide you with my comments today on this important proposed legislation.**

2. **My name is Lou Smith and I have worked in the insurance industry for the last 31 years. I have worked for Fiserv Health of Kansas, in Wichita, for the last 17 years where I am involved in the marketing of and consulting for Employee Benefits. I am currently the Legislative Chair for the Wichita Association of Health Underwriters which is the local chapter of the National Association of Health Underwriters. I am appearing here today in support of this important Bill.**

3. **As you know, most employers are struggling with the rising cost of healthcare and the related health insurance premiums. Every week I work with Kansas employers and their difficult decisions about their respective Employee Benefit plans. The common theme is raising deductibles, raising coinsurance and raising the employee's premium contribution levels. Employers are constantly seeking methods by which they can handle the cost of providing this important benefit to their employees and dependents.**

4. **Information can be an extremely effective tool in this quest employers have for lowering their costs. Most carriers are willing partners with their clients to assist them in this search. Claim data can be very important to an employer or his broker to analyze and make recommendations of possible plan changes to mitigate rising costs. My discussion today is brief so I want to focus on HB 2689 and how this is related.**

   A. **The Bill specifically provides for premium, claims, and number of employees. This information would indicate a "loss ratio" and indicate whether of not the premium has been sufficient to cover the associated claims. Employers recognize the importance of the carrier covering their expenses but want to be assured of a balance in the premiums set.**
   B. **Detailed claim information is specified for claims over $10,000. This information is critical to an employer. For example: Was the claim paid for a legitimate employee or dependent? Was it a covered**

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expense by contract? Was it a Workers Compensation claim? Was it covered by No Fault as a result of an auto claim? Was this a one time occurrence or will it be an ongoing expense? For example, an ongoing cancer claim is much more important to know about than a resolved broken leg.

C. Trends in large claims can be reviewed for possible intervention in the future. For example, large claims associated with asthma, diabetes, or premature births may warrant the intervention of better Disease Management skills to hold down future similar expenses. Without the appropriate data, no such intervention can be contemplated.

5. **I am a firm believer in the free market system and feel strongly that the marketplace can be an effective tool by allowing competition to do what it does best. Employers can use this tool to their advantage in negotiating with their incumbent carrier or perhaps seek competitive bids for their benefits. Without this important data tool, an employer or broker is restricted from getting the most competitive price from a prospective bidder. Carriers who review the claim history and discover several large claims, will be very hesitant to "sharpen their pencil" when pricing a proposal. The bidding carrier will have to "load" their rates to compensate for known large claims---since they have no idea as to its disposition. If an employer does not have this information, he will not get the best price available. Accordingly, Kansas Employers and thus Kansans will pay a higher price than perhaps warranted by the incumbent carrier. This will force even more Kansans into the ranks of the uninsured when cost rise inordinately.**

6. **Several other states, including Oklahoma and Virginia have already passed similar legislation and others are considering the same action. You will hear testimony today regarding HIPAA and I believe that this Federal law specifically allows the release of this information. Any perceived reluctance to release this data can be allayed by the signing of a "Business Associate's Agreement" and the employer would thus absolve the carrier of any "privacy" concerns.**

7. **The proposed HB 2689 will be an important tool to help Kansans hold down future increases in health care and thus warrants your careful consideration. I respectfully request you pass and recommend this legislation to the House.**

Thank you,

Lou Smith, Director
Fiserv Health of Kansas

Testimony on House Bill 2689
Before the House Insurance Committee
By Larry Magill
Kansas Association of Insurance Agents
February 17, 2004

Thank you Madam Chair and members of the Committee for the opportunity to appear today in support of House Bill 2689, a proposal we asked the Committee to introduce. My name is Larry Magill and I represent the Kansas Association of Insurance Agents. Our members write all kinds of insurance for numerous companies as independent agents. We write probably 70% of the business property and liability insurance in Kansas and a large share of the group health insurance market that is not written direct by Blue Cross/Blue Shield of Kansas. Even some of their group insurance business is placed with them by my members on a brokerage basis.

With HB 2689, the legislature has the opportunity to say to the group health insurance markets in Kansas, beginning with Blue Cross but including all of them, that they must provide enough information to the business so that it can shop the market for the best proposal available in terms of cost, coverage and service. If you do not pass HB 2689, you are saying to the insurance companies that it is ok to withhold that vital claim information and, in effect, hold them hostage to whatever the current carrier wants to charge.

This Is A New Problem
It has just materialized since the privacy requirements of the Health Insurance Portability and Accountability Act took effect for large groups on April 14, 2003. And in fact, in most states it's still not a problem since the dominant insurers in those states, for the most part, have not chosen to withhold claim information from large employers. (This is based on a survey of my counterparts around the country.)

You have the power, with this bill, to lower the cost of group health insurance.
It's not often that someone can stand before you and say that their bill has the potential to lower the cost of health insurance. This bill does. In fact, without it, you will almost certainly raise the cost of health insurance for the businesses that are denied the information they need to shop the health insurance market for the best cost and coverage available. And you will be saying to businesses that they will not be able to audit the claims paying practices of their health insurance company for accuracy and appropriateness.

Bill Addresses Two Areas of Claims Information
Our proposal is relatively simple and straightforward. Part of it deals with large group health information and part of it deals with property and casualty loss runs.

Health Insurance Claims Information
Basically the bill does the following with respect to large group health insurance:

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Date: 2/17/04
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- It applies to groups of over 50 lives. That's because small groups, under 50 lives, are subject to guaranteed issue requirements and agents must obtain statements of health on each employee and covered dependent and submit those to the carrier that is quoting. Under small group reform, the insurer can only increase their banded rate by 15% for the experience of the group. Not true for groups over 50. The larger they are the more their rate is based on their expected losses.
- Requires a breakdown of claims experience by month, by premium and paid claims in 3 categories of hospital, professional services and prescription drugs and number of employees.
- Requires a deductible utilization report to show how much of the deductible at a point in time has been satisfied by the covered individuals
- Requires large claim information for up to 24 months, if the insurer has been the carrier that long including the person's identity, the diagnosis, to the extent known, the current status of the person, and the identity of the health care provider.
- Requires that the information be provided without charge unless requested more than twice in one year
- Allows the Kansas Insurance Department to approve the charge, if any
- Requires that the information be provided within 30 days of the request
- Requires the employer to agree to comply with the information protection provisions of HIPAA and to use the information only in a fashion allowed by HIPAA
- Provides that violations of the act will be violations of the Unfair Trade Practices Act with respect to not providing the required information. All the HIPAA penalties would apply as well.

Property, Liability, Workers Compensation, Auto and Related Losses
The bill is simpler in regard to claims information for property and casualty risks. It simply requires that the insurer provide the insured with their claims information for up to 5 prior years, if the insured has been with the insurer that long. Insurers quoting on commercial risks today are commonly requesting this amount of information. Without it, they often will refuse to quote.

KAIA is aware of one instance where a carrier refused to provide their previous insured with their loss runs unless they paid approximately $300. When KAIA checked with the Kansas Insurance Department, we found that there is no statute requiring carriers to provide the claim information and nothing about whether they can charge for it.

The Proposal Accomplishes Three Goals:

1. **It allows the insured to shop the market for the best cost and coverage**
2. **It allows the insured to analyze their plan and make intelligent decisions about coverage changes that can control costs without exposing the covered employees to serious loss**
3. **It allows the insured to audit the claims payments of the insurer for appropriateness**

Without full access to their claims payments the insured does not:

- Know if a claim should have been turned into the workers compensation carrier
- Know if the claimant was a covered employee or dependent
- Know if the services are covered under the plan

Without access to their claim information for shopping the market, they cannot tell a prospective insurer:

- If the large claim individuals are cured
- If the large claim individuals are still employed or are still covered dependents
- If the large claim individuals represent continuing costs or increasing costs

And without this detailed information, the employer cannot:

- Negotiate with the current insurer for the best possible renewal rate increase
- Discuss possible changes in plan design to save money and lower costs

Congress Never Intended HIPAA to Prevent an Employer From Shopping
Since HIPAA became effective for large groups last April 14th, some insurers have hidden behind questionable interpretations of the act's privacy requirements to deny access to vital plan management information to the sponsoring employers. Congress was smart enough to recognize the disastrous effects of locking employers in with their group health carrier and never intended that result.

The Federal government knew that if they did not allow the employer to obtain protected health information (PHI) on their employees, they would effectively "lock in" the employer to their current group health carrier. That would put the employer at the mercy of the group health insurer who could charge essentially whatever they wanted and the employer would not have the detailed claim information to dispute the future expected claims, check the accuracy of past payouts or examine ways they could manage their group health costs through plan design.

We can't say this in strong enough terms, not allowing employers access to their claim data to obtain the lowest cost health insurance will cost them and their employees tremendous amounts of money and ultimately may force many employers to drop their company sponsored health plans, increasing the number of uninsured.

An insurer asked to quote on a large commercial group health plan without sufficient information will **load the rates** to compensate for that uncertainty. The incumbent insurer is at no such disadvantage and, in fact, can charge more in most cases than they might otherwise.

Other conferees today will give you a more detailed explanation of HIPAA requirements. Basically the bill addresses privacy concerns by using the provisions in HIPAA to allow the employer to certify that they will protect the PHI (Personal Health Information) they

are given and use it in the permitted manner to obtain competitive group health insurance quotes and manage their plans.

Without detailed large claim information, the insured and their consultant/broker cannot:

1. **Check Coordination of Benefits.** The claim could have been paid by someone other than the group health plan, such as a spouse's plan, workers compensation, auto insurance PIP or other medical payments
2. **Determine if the Person is a Covered Person.** The insurer may have paid a claim for a non-covered individual, one no longer part of the group, or a divorced spouse not covered by COBRA
3. **Determine if Benefits Were Payable.** Insurers do make mistakes and pay claims erroneously.
4. **Confirm the Accuracy of Claims Information Used in Rating.** Incorrect information can adversely impact the renewal premium quote from the existing carrier.
5. **Identify Non-recurring Claims.** The information may be exactly correct but the carrier may be charging in the renewal rates for employees who have left the firm, are deceased, were cured, or for accidental injuries with no on-going expenses.

Most states have not addressed the area at all but Oklahoma, Texas, and Virginia have recently passed legislation and Missouri and Kentucky are considering bills. The remainder of the states indicated that the carriers in their state were cooperating in providing the detailed claim information needed to obtain competitive proposals and manage their group health risks.

The Charges by Carriers For Claim Information Can be Exorbitant

We're aware of instances where one dominant insurer quoted a cost of $2-3,000 for a data "dump" needed to manage the benefit design of a large group. This is information routinely provided in other states to brokers using this particular software but denied in Kansas, at any price.

We're aware of one large self-insured in Wichita that was quoted a cost of thousands of dollars for their claim data despite being self insured and presumably entitled to it.

Opponents Arguments:

The insurance carriers will likely argue that:

- They provide the needed information. *Not true. They may provide it when threatened with lawsuits but it is not willingly. And then they only provide some of it. This legislation would insure that they provide all the needed information all of the time without having to be threatened or cajoled into giving it.*
- They give out as much information as they get on typical new business submissions. *Not true. Carriers require large claim information including the likely future payout before they will give a competitive quote. Otherwise, they will load the rate for the uncertainty, which is exactly what the incumbent carrier wants.*

- HIPAA doesn't allow them to give out the information. *Not true. The bill provides for a HIPAA certification that will protect them. They have admitted that it's a business decision on their part. They often consider the information their property. We think it belongs to the employer. We suspect that they simply want to protect themselves from competition.*
- They only charge $100 for a large claim report. *Not true. The report does not provide the information called for in the bill, only part of it. They have quoted prices as high as $2-3,000 for a complete data dump to allow a broker to analyze an employer's claims and make recommendations. Now they refuse to provide the data even when the insured agreed to pay the exorbitant price.*
- They give out deductible utilization reports for a charge of $100. *Not true. They told one broker that they would only give that information out if the insured leaves Blue Cross. The broker needed it to make deductible change recommendations but was not planning on leaving Blue Cross.*

Failing to Act Could Be Disastrous

Once one insurer is seen to get away with withholding claim information, the rest of them will quickly follow suit. This will be especially true if that carrier is dominant in the marketplace. The other insurers will have no choice but to try to protect their book of business as well.

An open, competitive marketplace and a well-informed plan manager at the employer level are two key ingredients to hold down the health insurance cost increases facing employers and employees today. If we are to have an employer-sponsored-plan base for our health insurance system in this country, we must give them the tools to deal with the insurers. Blind faith in the carriers is not a viable option and trusting them to have the employers' best interests at heart is naïve, at best. We urge you to pass House Bill 2689 out favorably and would be happy to answer questions or provide additional information.

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[redacted]

RUN DATE: 01/30/2002

CONTINENTAL WESTERN INSURANCE COMPANY
CLAIMS HISTORY REPORT
COVERAGE SUMMARY

1679 & 15 PAGE 1

		NBR OF CLAIMS	PAID LOSSES	RESERVE AMOUNT	TOTAL INCURRED
HE04400 - NO CLAIMS					
EFFECTIVE DATE / EXPIRATION DATE					
04 30 2001	04 30 2002	000	0.00	0.00	0.00
HE04420 - NO CLAIMS					
EFFECTIVE DATE / EXPIRATION DATE					
04 30 2001	04 30 2002	000	0.00	0.00	0.00
HE04421 - AUTOMOBILE COVERAGE					
EFFECTIVE DATE / EXPIRATION DATE					
04 30 2001	04 30 2002	002	844.03	0.00	844.03
04 30 2000	04 30 2001	000	0.00	0.00	0.00
04 30 1999	04 30 2000	000	0.00	0.00	0.00
04 30 1998	04 30 1999	000	0.00	0.00	0.00
04 30 1997	04 30 1998	000	0.00	0.00	0.00
AUTOMOBILE TOTAL		002	844.03	0.00	844.03
HE04423 - NO CLAIMS					
EFFECTIVE DATE / EXPIRATION DATE					
04 30 2001	04 30 2002	000	0.00	0.00	0.00
HE04450 - NO CLAIMS					
EFFECTIVE DATE / EXPIRATION DATE					
04 30 2001	04 30 2002	000	0.00	0.00	0.00
TOTALS FOR POLICIES TAKING EFFECT IN:					
2001		002	844.03	0.00	844.03
2000		000	0.00	0.00	0.00
1999		000	0.00	0.00	0.00
1998		000	0.00	0.00	0.00
1997		000	0.00	0.00	0.00
TOTAL		002	844.03	0.00	844.03

ZERO AMOUNTS INDICATE NO LOSSES WERE EXPERIENCED OR POLICY WAS NOT IN EFFECT

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CONTINENTAL WESTERN INSURANCE COMPANY
CLAIMS HISTORY REPORT
CONTRACTORS LOSS LISTING - AUTO

INSURED NAME: [redacted]
POLICY # [redacted] 04-30-2001 TO 04-30-2002

NAME OF DRIVER / AGE OF DRIVER / CLAIM NUMBER & STATUS / NAME OF ADJUSTER 1 / NAME OF ADJUSTER 2	DATE OF LOSS / TIME OF LOSS / LOCATION CODE / CLAIMANT	LOCATION OF LOSS / ACCIDENT DESCRIPTION / LOSS CODE	TYPE OF LOSS	PAID LOSSES	RESERVE AMOUNT	TOTAL INCURRED
[redacted] 16 15A506195 CLOSED [redacted] SHERYL [redacted] MARY KAY	05-30-2001 [redacted] CONS	KS, WICHITA, SG COUNTY EXTENSION @ 21ST IV BACKED OUT OF PARKING SPACE & HIT CV	PD	844.03	0.00	844.03
			COLLISION	0.00	0.00	0.00
			TOTAL	844.03	0.00	844.03
15A506152 CLOSED [redacted] DON [redacted]	05-15-2001 BUCK'S [redacted]	8710 W CENTRAL AVE WICHITA KS 00 FORD 1683 EMPLOYEE WAS PULLIND SKID LOADER WHICH CAUGHT 16' AWNING DAMAGING THE AWNING AND SUPPORTS	COLLISION	0.00	0.00	0.00
			TOTAL	0.00	0.00	0.00
		TOTALS FOR POLICY YEAR 2001-2002	2 CLAIMS	844.03	0.00	844.03

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Workers Compensation

21 Period: 01/01/2003 - 01/01/2004

20 Period: 01/01/2003 - 01/01/2004 Premium: $0.00

22 Period: 01/01/2004 - 01/01/2005

Policy: [redacted]

Date of Loss	Occ #	Clmt #	Claim #	Adjuster #	Type of Loss	Outstanding Reserve	Paid/ Recovery	Paid/ Expense	Status
Policy: 402397183 20									
01/03/2003	1	1	7009957	1072	WC Medical	$0.00	$0.00	$0.00	Closed
43 fmale/fell down steps/multiple injuries									
Policy: 402397183 21									
02/01/2003	1	1	7013469	1033	WC Indemnity	$10638.00	$5204.79	$0.00	Open
42/F/Server/claims injured shoulder, unknown how									
02/01/2003	1	1	7013469	1033	WC Medical	$15633.55	$6675.11	$2944.90	Open
42/F/Server/claims injured shoulder, unknown how									
Policy: 402397183 20									
02/07/2003	1	1	7010611	1024	WC Medical	$0.00	$100.00	$0.00	Closed
age 18 / chipped tooth / floor									
02/24/2003	1	1	7010902	1029	WC Medical	$0.00	$0.00	$0.00	Closed
59/corp vice pres/fell on ice/hurt tailbone,back,hands									
Policy: 402397183 21									
03/17/2003	1	1	7011310	1072	WC Medical	$0.00	$0.00	$0.00	Closed
23/clmt slipped on water and fell injuring right knee									
03/23/2003	1	1	7011538	1072	WC Indemnity	$0.00	$0.00	$0.00	Closed
32/injured arm wher lifting									
03/23/2003	1	1	7011538	1072	WC Medical	$0.00	$0.00	$0.00	Closed
32/injured arm wher lifting									
03/31/2003	1	1	7011933	1017	WC Medical	$0.00	$0.00	$0.00	Closed
46 male/clmt cut finger on glass									
04/18/2003	1	1	7018461	1051	WC Medical	$0.00	$325.67	$16.83	Closed
18/tripped on curb, lacerations, minor concussion									
05/16/2003	1	1	7013216	1024	WC Medical	$0.00	$965.30	$0.00	Closed
age 17 / sliced hand / kitchen									
05/16/2003	2	1	7013382	1034	WC Medical	$176.00	$324.00	$0.00	Open
18/server/carrying tray w glasses & tripped/cut hand									
06/05/2003	1	1	7014164	1033	WC Medical	$0.00	$0.00	$0.00	Closed
16/m/sprained rt ankle when slipped and fell									
06/05/2003	2	1	7015571	1017	WC Medical	$0.00	$0.00	$0.00	Closed
19 female/clmt cut left pinky finger									
06/06/2003	1	1	7015997	1034	WC Medical	$0.00	$549.05	$0.00	Closed
17/floor staff/cut hand on plastic handle on locker									
06/14/2003	1	1	7014206	1051	WC Medical	$2059.10	$2861.75	$0.00	Open
43/maintenance slipped on water, twisted knee									
06/14/2003	2	1	7014562	1002	WC Medical	$0.00	$105.00	$15.60	Closed
17 male/clmt got Drano in his eye									
06/19/2003	1	1	7014807	1017	WC Medical	$0.00	$250.05	$0.00	Closed
37 male/clmt cut middle finger									
06/26/2003	1	1	7014741	1002	WC Medical	$0.00	$0.00	$0.00	Closed
31/male slip and fal ankle sprain									
06/28/2003	1	1	7014631	1063	WC Medical	$0.00	$0.00	$0.00	Closed
19, f/bruised, jammed left thumb									
06/29/2003	1	1	7014786	1002	WC Medical	$9.87	$0.00	$0.00	Open
31/male/slipped on wet floor sprained ankle									
06/29/2003	2	1	7015569	1017	WC Medical	$0.00	$0.00	$0.00	Closed
HISTORY ONLY cut hand washing popcorn warmer									
06/29/2003	3	1	7015577	1029	WC Medical	$0.00	$0.00	$0.00	Closed

[redacted]

Travelers

Detail Loss Report

Accident Date Range: 01-01-1999 to 02-17-2004

Claimant	Adj Off	FP	Claim Number	Date Of Loss	Close Date	O/C		Total	Claim	Medical	Expense
[redacted] MARK D	077	CM	BXM6371	06-07-2001	01-18-2002	C	Inc:	$263.00	$0.00	$253.00	$10.00
WHILE WORKING ON THE SLITTER MACHINE TRYING TO CUT A CORE- LACERATION TO LEFT INDEX FINGER							Pd:	$262.99	$0.00	$253.00	$9.99
							O/S:	$0.00	$0.00	$0.00	$0.00
[redacted] LEROY	478	CB	AWU6428	09-18-2001	05-04-2002	C	Inc:	$10,266.00	$6,029.00	$3,638.00	$599.00
LIFTING MATERIAL.							Pd:	$10,266.35	$6,029.10	$3,637.90	$599.35
							O/S:	$0.00	$0.00	$0.00	$0.00
[redacted] STEVE	077	CM	ATI3705	06-21-2002	10-17-2002	C	Inc:	$334.00	$0.00	$316.00	$18.00
EE DROPPED A DIE. WHEN HE WENT TO CATCH IT HE CUT HIS HAND ON THE RULE.							Pd:	$333.79	$0.00	$315.70	$18.09
							O/S:	$0.00	$0.00	$0.00	$0.00
[redacted] SANDRA M	077	CB	ATI9553	10-25-2002	12-30-2003	C	Inc:	$25,358.00	$11,437.00	$12,398.00	$1,523.00
COMPLAINED OF NUMBNESS AND PAIN IN HANDS BECAUSE OF SQUEEZING GLUE GUN TO MAKE PARTS./ WORKING GLUE GUN TO MAKE PARTS FOR WINDOW FRAMES./ SHE IS SAYING THE PROCESS OF WORKING THE GLUE GUN AND SQUEEZING TO MAKE PARTS IS CAUSING INJURY.							Pd:	$25,357.25	$11,436.57	$12,397.97	$1,522.71
							O/S:	$0.00	$0.00	$0.00	$0.00
[redacted] BRANDON	077	CB	ATI5434	01-25-2002	01-07-2003	C	Inc:	$221.00	$0.00	$221.00	$0.00
SHORT OF BREATH - HISTORY OF ASTHMA							Pd:	$221.16	$0.00	$221.16	$0.00
							O/S:	$0.00	$0.00	$0.00	$0.00
[redacted] STEVE	478	AD	ANQ0818	01-29-2003	04-09-2003	C	Inc:	$574.00	$574.00	$0.00	$0.00
CLMT ALLEGES THAT INSD WAS STOPPED AT LIGHT AND ROLLED BACK INTO HIS VEHICLE CAUSING MINOR DAMAGE TO FRONT END. SEE ATTACHED INSD DRIVER WRITTEN STATEMENT.							Pd:	$573.91	$573.91	$0.00	$0.00
							O/S:	$0.00	$0.00	$0.00	$0.00
[redacted] ROGER V	077	CM	AWC1603	09-19-2001	12-22-2001	C	Inc:	$1,323.00	$0.00	$1,283.00	$40.00
HE SLIPPED ON SOME MATERIAL THAT WAS ON THE FLOOR / SPRAINED LEFT ANKLE & KNEE.							Pd:	$1,322.55	$0.00	$1,282.50	$40.05
							O/S:	$0.00	$0.00	$0.00	$0.00