Approved: March 21, 2006
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairman Clark Shultz at 3:30 P.M. on March 14, 2006 in Room 527-S of the Capitol.

All members were present except:
Representative Bob Grant- excused
Representative Mitch Holmes- excused
Representative Scott Schwab- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Ken Wilke, Revisor of Statutes Office
Sue Fowler, Committee Secretary

Conferees appearing before the committee:
Senator Barbara Allen, District 8, Overland Park, KS
Gary Sherrer, Leawood, KS
Matt All, Governor's Office, Lawrence, KS
Larrie Ann Lower, Kansas Assoc. of Health Plans, Topeka, KS
Jarrod Forbes, Kansas Department of Insurance, Topeka, KS
Jerry Slaughter, Kansas Medical Society, Topeka, KS
Sky Westerlund, Kansas Chapter of the National Association of Social Workers, Topeka, KS
Terri Roberts, Kansas State Nurses Assoc, Topeka, KS
Ira Stamm, Ph.D., Topeka, KS
Woody Moses, The Kansas Aggragate Producers Association, Topeka, KS
Clint Patty, Friedon, Haynes & Forbes Law Firm, Topeka, KS
Mark Wilkerson, IMA of Kansas, Lenexa, KS
Ramon Gonzalez, Hamm Quarry, Inc, Perry, KS
Lew Ebert, Kansas Chamber, Topeka, KS
Ken Daniel, KsSmallBiz.com, Topeka, KS
Cory Peterson, AGC of Kansas, Topeka, KS
Bob Totten, Kansas Contractors Association, Inc., Topeka, KS
Larry Magill, Kansas Association of Insurance Agents, Topeka, KS
William Skepnek, Kansas Trial Lawyers, Lawrence, KS
Callie Denton, Kansas Trial Lawyers, Topeka, KS
Charles Wheelen, Osteopathic Association, Topeka, KS

Others attending:
See attached list.

Hearing on:

SB 522: Health insurance; internal review process

Melissa Calderwood, Legislative Research Department, gave a brief overview on **SB 522**.

Proponents:
Gary Sherrer, (Attachment #1), appeared before the committee in support of **SB 522**.
Matt All, Governor's Office, (Attachment #2), presented testimony in support of **SB 522**.
Larrie Ann Lower, Kansas Assoc. of Health Plans, (Attachment #3), gave testimony in support of **SB 522**.
Jarrod Forbes, Kansas Department of Insurance, (Attachment #4), appeared before the committee in support of **SB 522**.
Jerry Slaughter, Kansas Medical Society, (Attachment #5), gave testimony in support of **SB 522**.
Sky Westerlund, Kansas Chapter of the National Association of Social Workers, (Attachment #6), presented written testimony in support of **SB 522**.
Terri Roberts, Kansas State Nurses Assoc, (Attachment #7), presented written testimony in support of **SB 522**.
Sen. Barbara Allen, District 8, (Attachment #8), presented written testimony in support of **SB 522**.

MINUTES OF THE House Insurance Committee at 3:30 P.M. on March 14, 2006 in Room 527-S of the Capitol.

Neutral:
Ira Stamm, Ph.D., (Attachment #9), appeared before the committee regarding **SB 522**.

Hearing closed on **SB 522**.

Hearing on:

SB 422: **Surety Bonds - eliminating the need for more than one surety in certain statutes**

Melissa Calderwood, Legislative Research Department, gave a brief overview on **SB 422**.

Proponent:
Larry Magill, Kansas Association of Insurance Agents, (Attachment #10), appeared before the committee in support of **SB 422**.

Hearing closed on **SB 422**.

Hearing on:

SB 512: **Silicosis Claims Act**

Melissa Calderwood, Legislative Research Department, gave a brief overview on **SB 512**.

Proponents:
Woody Moses, The Kansas Aggragate Producers Association, (Attachment #11), appeared before the committee in support of **SB 512**.
Clint Patty, Friedon, Haynes & Forbes Law Firm, (Attachment #12), gave testimony in support of **SB 512**.
Mark Wilkerson, IMA of Kansas, (Attachment #13), presented testimony in support of **SB 512**.
Ramon Gonzalez, Hamm Quarry, Inc, (Attachment #14), gave testimony in support of **SB 512**.
Lew Ebert, Kansas Chamber, (Attachment #15), presented written testimony in support of **SB 512**.
Ken Daniel, KsSmallBiz.com, (Attachment #16), appeared before the committee in support of **SB 512**.
Cory Peterson, AGC of Kansas, (Attachment #17), presented written testimony in support of **SB 512**.
Bob Totten, Kansas Contractors Association, Inc., (Attachment #18), presented written testimony in support of **SB 512**.
Larry Magill, Kansas Association of Insurance Agents, (Attachment #19), gave testimony in support of **SB 512**.

Opponents:
William Skepnek, Kansas Trial Lawyers, (Attachment #20), presented testimony in opposition to **SB 512**.
Callie Denton, Kansas Trial Lawyers, (Attachment #21), appeared before the committee in opposition to **SB 512**.

Neutral:
Charles L. (Chip) Wheelen, Osteopathic Association, (Attachment #22), appeared before the committee regarding **SB 512**.

Hearing was closed on **SB 512**.

Representative Trimmer recommended without objection of committee members to approve the committee minutes of March 7, 2006 and March 9, 2006.

Adjourned at 6:05 P.M.

Next meeting will be Thursday, March 16, 2006, 3:30 P.M., Room 527-S.

House Insurance Committee
Guest Sign In Sheet
Tuesday, March 14, 2006

Name	Representing
Lonnie Ann Bowers	KAHP
Ira Stamm	Cancer Survivors
Alex Kotoyantz	P.I.A.
Dominic Kujawa	ICTLA
MARK WILKERSON	IMA
Chip Wheelen	Assn of Osteopathic Med.
LEW EBERT	KANSAS CHAMBER
GARY SHERRER	SeHR
Wendy Mays	ICAPA
Wesley Harris	ICAPA
Clint Patty	Foreden, Hayposs & Forbes (KAPA)
Mary Barrett	
Sky Westerlund	KNASW
~~Steve~~ O'Neal	KANSAS INSURANCE DEPT.
Bob Miller	Farmers Alliance
Scott Heidner	KADC
Tom Whitaker	KMCA
[illegible]	KID
Steve Onel	KID
Crystal Clydesdale	Rep Carter
Callie Tidenton	ICTLA

House Insurance Committee

Testimony of Gary Sherrer

Senate Bill 522

March 14, 2006

Thank you for the opportunity to speak in support of Senate Bill 522. I appear here today as a private citizen representing no group or organization but supporting legislation that will touch the lives of thousands of Kansans. Senate Bill 522 is nothing less than a "Bill of Rights" for Kansans who are subjected to the appeals process of health insurance companies.

First let me provide you some background on how I discovered there is no protection of basic consumer rights in the health insurance appeals process. In July of last year my wife Judy was diagnosed with a rare and very aggressive form of lymphoma. Only one to two percent of lymphoma patients develop this form of the disease. Long term prognosis is not good and the treatment is aggressive chemotherapy followed by a stem cell transplant. The transplant procedure is one in which a persons stem cells are "harvested" from their blood, stored, then following high dose chemotherapy are replaced. This can only be done when the cancer is in remission and thus timing is critical. One of the Doctors Coventry Health Insurance of Kansas, Inc. used in the appeals evaluation noted that a stem cell transplant can double the survival chances of a patient with my wife's diagnosis.

In August of 2005 our health insurance company, Coventry Health Insurance of Kansas, Inc., authorized Evaluation Procedures for an "Autologous Peripheral Stem Cell Transplant" and in their letter of August 15 noted "Autologous Peripheral Stem Cell Transplants are covered when prior-authorized and obtained at a facility as determined by us." My wife met the requirements of the evaluation procedures and her Doctors requested coverage for the transplant itself. Coventry denied the coverage. Our Doctors appealed and the first level appeal was denied. We were told we could have a second level appeal at which time we could appear before the review group. Because time was important we asked to waive the second appeal and go directly to the state process of appeal. We knew that the Coventry staff were not going to vote in our favor. They had not at level one (two independent Doctors

said yes, two said no and Coventry broke the tie.) and we were confident they would protect the company's money on round two. As you can see in the letter dated October 4, 2005 they denied our right to waive the second appeal. At one point they even wrote to deny an expedited appeal, but after many phone calls they relented on this issue.

What was most troubling was the hearing itself. Note in the letter of November 8, 2005 setting the "rules" for the hearing that they decided I could have 15 minutes to advocate a life saving procedure for my wife of 40 years. No recording of the hearing would be made. I could not have an attorney unless they and the Committee said so. (Yet their attorney was on the conference call during the entire appeal hearing.) At the hearing when I asked a question I was told that there were to be no questions from me and that I was just to make my presentation. In the letter to their Medical Director I asked questions so I could prepare for the hearing. He refused to answer them. Then at the hearing when I asked questions I was told I could not. To this day my questions have never been answered. There were to be five people voting on this appeal. Three Doctors, none of whom were at the meeting or on the conference call, a medical director from the Coventry of Tennessee who was on a conference call, and a gentleman who was identified as a Coventry policy holder who was present in the room. After my 15 minute presentation no questions were asked of me and the appeal hearing concluded. We finally were able to utilize the state appeal process which was handled extremely well by the Kansas Insurance Department We did receive an adverse ruling. While we disagree with it, as do our Doctors, we accept it and are prepared to pay for the treatment which will cost between $75,000 and $100,000. Unfortunately during the delays my wife had to go through additional chemotherapy which I believe has contributed to her inability to produce enough stem cells for harvesting. She has been accepted into a clinical trial for a new drug that may help.

While this issue is personal to me because of Judy I am here today as someone who has spent time in the development of public policy and strongly believes this bill is needed public policy. The issue is should Kansans have protection by statue of some fundamental rights in the health insurance appeal process. Let me make it clear that I am not making a judgment on other health insurance companies and how they handle the appeal process. I am sure it varies from company to company. That is just the point—it should not vary. Every Kansan, regardless of the company they do business with should be protected with a guarantee of these basic rights. The health insurance industry does not operate in a pure free market environment. I doubt there are many in this room that [illegible] they would be covered by. Government regulation is appropriate and necessary.

I am asking you to ensure that if your constituents are ever part of an appeal process they will have the right to waive it; the right to be given a reasonable amount of time to make their case; the right to ask and receive answers to relevant questions; the right to have those who are going to vote hear their appeal; the right to see all the records relevant to the appeal; the right to be represented by an attorney or person of their choosing; the and the right to record the proceeding.

There is nothing unreasonable about the granting of these rights. Members of the committee we are not talking about protection of insurance companies. We are talking about protecting Kansans who are dealing in life and death matters. Kansas who will find themselves unable to pay for treatment their Doctor prescribes for them or their loved ones. Catastrophic illness has an impact on the patient and their family that cannot be put into words. To compound that by putting them at the mercy of the health insurance companies during the appeals process is inexcusable. Please support a consumer "Bill of Rights", please support Senate Bill 522.

THANK YOU

COVENTRY
Health Care of Kansas, Inc.
With you when it matters.™

October 4, 2005

Kansas City Cancer Center
Attn: Sunil Abhyankar, M.D.
4320 Wornall Road, Suite 220
Kansas City, MO 64111

Member: Judith Sherrer
Member #: 901130885*02
Issue: Autologous Stem Cell Transplant

Dear Dr. Abhyankar:

This letter is in response to your first level appeal requesting authorization for an autologous stem cell transplant for the above listed member.

After careful review of all available information and the member's plan benefits, the First Level Appeal Committee, including independent review by three (3) physicians board-certified in Hematology and Oncology has made the determination to uphold the Plan's original denial. The Committee's decision was based on the following:

According to the member's Coventry Health Care of Kansas, Inc. POS Evidence of Coverage as purchased the employer, Bank of Blue Valley, Section 6, states the following items are excluded from Coverage:

"Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;"

Section 1.44 of the member's POS Evidence of Coverage states:

"A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- *Any drug not approved for use by the Federal Food and Drug Administration ("FDA"); any drug that is classified as an Investigational New Drug ("IND") by the FDA; any drug that is proposed for off-label prescribing. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.*

- *For Kansas-based Employer Groups, off-label prescribing for the treatment of cancer is not considered Experimental or Investigational.*

- *Any health product or service that is subject to Investigational Review Board (IRB) review or approval.*

Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered

• Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts."

An autologous stem cell transplant has been requested for this member. It is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

The member has the right to a second level appeal (Grievance Committee). Coventry Health Care of Kansas, Inc. received a request from Ms. Sherrer on November 1, 2005 to have the second level of appeal waived. This request has been denied, as we would like the member to have the benefit of all levels of appeal at the plan level. Although this is an internal review, we would like to give the member every opportunity to present the issues relevant to this case.

The Second Level Committee will include independent review by three (3) board-certified oncologist/hematologists. Please see the attached page for further information on the member's appeal rights. Furthermore, if the member requests a second level appeal, we will be happy to process it on an expedited basis.

Thank you for contacting Coventry regarding this matter, and allowing us the opportunity to respond. If you should have any questions regarding other issues, please contact our Customer Service Department at 1-800-969-3343, available Monday through Friday, 8 a.m. to 5 p.m.

Sincerely,

Karen L. Emerick
Appeals Coordinator
Coventry Health Care of Kansas, Inc.

cc: Judith K. Sherrer
2217 W. 124th Street
Leawood, KS 66209

Enclosures: Member Appeal Rights

COVENTRY
Health Care of Kansas, Inc.
With you when it matters.™

November 8, 2005

Gary L. Sherrer
2217 W. 124th Street
Leawood, KS 66209

RE: Member: Judith K. Sherrer
ID#: 901130885*02

Dear Ms. Sherrer:

The Appeals Unit of Coventry Health Care of Kansas, Inc. (Coventry) is in receipt of your letter requesting a Second Level Appeal regarding authorization or your wife, Judith to receive benefits for an autologous stem cell transplant. Your letter was received in our office on November 7, 2005.

The Second Level Grievance Committee is scheduled to meet on November 9, 2005 at 3:00 p.m. You have the right to attend this meeting, either in person or by telephone.

Please fax to me at fax number: 1-866-769-2408 any additional documentation that you wish to present to the committee as soon as possible. This information will be included in the informational packet sent to the Committee Members. We must receive your information in a timely manner. The Grievance Committee is composed of:

- Coventry Members who are not employees;
- Employees of Coventry who are not involved in the incident that caused the grievance or have reviewed the case at a prior stage of the appeal process; and
- Clinical Peers if applicable.

You will be allowed fifteen (15) minutes to present your issues to the Committee. The hearing will be an informal proceeding intended to allow both parties to explain their position. The hearing will not be electronically recorded and neither party may be represented by an attorney without the approval of the other party and the members of the Grievance Committee.

The Committee members will arrive at a final decision by majority hand vote. You will be mailed a letter advising you of the Committee's determination. If you have any questions regarding this matter, please feel free to contact me at (816) 460-4382. Thank you for bringing these concerns to our attention. We appreciate your patience during the review process.

Sincerely,

Karen L. Emerick
Appeals Department
Coventry Health Care of Kansas, Inc.

October 31, 2005

James Utley, M.D.
Medical Director
Coventry Health Care of Kansas, Inc.
8320 Ward Parkway
Kansas City, Missouri 64114

Dear Dr. Utley;

In a letter dated October 21, 2005, you denied the request for coverage of an Autologous Peripheral Stem Cell Transplant. My intent is appeal this decision to the Insurance Commission of Kansas. To prepare my appeal I would like the following questions answered in writing. As time is of the essence I request your response as soon as possible.

Question #1
Is it the policy of Coventry to deny this treatment to all lymphoma patients? If not what are the exceptions and what is the basis for the exception?

Question #2
Has Coventry Health Care of Kansas ever provided coverage for Autologous Peripheral Stem Cell Transplant for any of its policy holders for any type of lymphoma ?

Question #3
If it is the policy of Coventry Health Care of Kansas to not allow this procedure why then , in a letter dated August 15th, 2005 did Coventry (Dr. Elizabeth Peterson) authorize "evaluation for possible Autologous Peripheral Stem Cell Transplant"—authorization #905920?

Question #4
Your reason for denial was that items excluded from coverage include "6)Procedures and treatments that the Plan determines to be Experimental or Investigational;". Sub Section 1862 (a) (1) (A) of the Medicare Manual states: Autologous Stem Cell Transplantation is considered reasonable and necessary for the following conditions and is covered under Medicare for patients with: "Resistant non-Hodgkins or those presenting with poor prognostic features following an initial response.". It seems unlikely that the Medicare program is involved in "experimental or investigational" programs. This procedure is used for lymphoma patients all over the United States and has been for years. It would appear that the Federal Government recognizes that, but a for profit insurance company does not. Can you explain the difference is approaches?

Coventry Health Care of Kansas has as its slogan "With you when it matters." This transplant really matters and you are clearly not with me.

Judith K. Sherrer
ID# 901130885-02

KANSAS
OFFICE OF THE GOVERNOR
KATHLEEN SEBELIUS, GOVERNOR

TESTIMONY ON SENATE BILL NO. 522

MATTHEW D. ALL

CHIEF COUNSEL TO THE GOVERNOR

BEFORE THE HOUSE COMMITTEE ON INSURANCE

Tuesday, March 14, 2006

Mister Chairman and Members of the Committee:

Thank you for allowing me to testify on Senate Bill 522. My name is Matthew D. All, and I am the Chief Counsel to the Governor. Before I took my current job, I had the honor of serving as the Assistant Insurance Commissioner under then-Commissioner Kathleen Sebelius.

Of all the things Commissioner Sebelius accomplished in that office, perhaps the most important was her work to enhance the rights and protections of Kansas consumers, particularly in health insurance. In 1999, for example, she worked with many of you to give consumers whose health insurers denied them treatment the right to an external, independent review of that denial.

Senate Bill 522 is another important step in protecting Kansas consumers. It would provide important safeguards for consumers facing a denial of health coverage. It would require health insurers to provide information about their internal review and appeal process, and would make the procedures for these appeals fairer and more sensible for consumers.

Few things in life are more difficult than having a serious illness, or caring for a loved one with a serious illness. Having to wade through a confusing and opaque review process is the last thing Kansans in that situation need. Senate Bill 522 will help those Kansans. We applaud Senator Allen for proposing this bill, and we urge you to support it.

CAPITOL BUILDING, ROOM 212S, TOPEKA, KS 66612-1590
Voice 785-296-3232 Fax 785-296-7973 http:/www.ksgovernor.org

Kansas Association
of Health Plans

212 SW 8th Avenue, Suite 200
Topeka KS 66603-3939

785-233-2747
Fax 785-233-3518
kahp@kansasstatehouse.com

Testimony before the
House Insurance Committee
SB 522
March 14, 2006

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

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are connected to managed care. KAHP members serve most all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid managed care and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on SB 522.

The KAHP is supportive of the process of internal review. The purpose of internal review is to enable insureds and their insurance companies to resolve disagreements about coverage. We recognize plans perform reviews differently but with the attached substitute bill, we can agree to establish basic standards for all health insurance companies to use. We understand other proponents can also support the substitute bill.

Many of the proposed amendments in the substitute version are included to bring the legislation in line with United States Department of Labor standards that plans must follow for ERISA businesses. In addition, several amendments are corrections necessary to fix unintended consequences that arose out of the Senate's amendments.

In conclusion, KAHP is supportive of requiring that plans provide insureds with a description of the plan's internal review process, granting an insured the ability to waive a second level of review within the plan's internal review process and providing basic rights to those insureds who elect to proceed with the second level of review. Thank you and I will be happy to answer any questions you may have.

House Insurance
Date: 3-14-06
Attachment # 3

HOUSE SUBSTITUTE FOR SENATE BILL 522

AN ACT concerning health insurance; providing the insured certain appeal rights regarding adverse health care decisions.

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

Section 1. (a) Every health insurance plan for which utilization review is performed shall include a description of the health insurance plan's procedures for an insured to obtain internal review of an adverse decision. This description shall include all applicable time periods, contact information, rights of the insured and available levels of appeal. If the health insurer uses a utilization review organization, the insured shall be notified of the name of such utilization review organization. The health insurance plan shall provide an insured with written or electronic notification of any adverse decision, and a description of the health insurance plan's review procedure, including the insured's right to external review as provided in K.S.A. 40-22a14 and amendments thereto.

(b) If the health insurance plan contains a provision for two levels of internal appeal or review of a health care decision which is adverse to the insured, the health insurance plan shall allow the insured to voluntarily waive such insured's right to the second internal appeal or review. Such waiver shall be made in writing to the health insurance plan and shall constitute the exhaustion of all available internal review procedures within the meaning of K.S.A. 40-22a14(d).

(c) If an insured elects to request the second internal appeal or review of a health care decision which is adverse to the insured, the insured shall have the right to appear in person before a designated representative or representatives of the health insurance plan or utilization review organization at the second internal appeal or review meeting. If a majority of the designated representatives of the health plan or utilization review organization who will be deciding the internal appeal or review cannot be present in person, by telephone or by other electronic means, at least one of those designated representatives who will be deciding the internal appeal or review shall be a physician and shall be present in person, by telephone or by other electronic means. No physician or other health care provider serving as a reviewer in an internal appeal or review of an adverse decision shall be liable in damages to the insured or the health insurance plan for any opinion rendered as part of the internal appeal or review.

(d) All second internal appeals or reviews shall provide that the insured has a right to:

(1) receive from the health insurance plan or utilization review organization, upon request, copies of all documents, records and other information that are not confidential or privileged relevant to the insured's request for benefits;

(2) have a reasonable and adequate amount of time to present the insured's case to a designated representative or representatives of the health insurance plan or utilization review organization who will be deciding the internal appeal or review;

(3) submit written comments, documents, records and other material relating to the request for benefits for the internal appeal or review panel to consider when

conducting the second review meeting both before and, if applicable, at the second review meeting;

(4) prior to or during the internal appeal or review ask questions relevant to the subject matter of the internal appeal or review of any representative of the health insurance plan or utilization review organization serving on the internal appeal or review panel provided that such representative may respond verbally if the question is asked in person during an insured's appearance before the internal appeal or review panel or in writing if the questions are asked in writing, not more than 30 days from receipt of such written questions.

(5) be assisted or represented at the second internal appeal or review meeting by an individual or individuals of the insured's choice; and

(6) record the proceedings of the second internal appeal or review meeting at the expense of the insured.

(e) An insured, or the insured's authorized representative, wishing to request to appear in person before the second internal appeal or review panel consisting of the health insurance plan's or utilization review organization's designated representative or representatives shall make the request to the health insurance plan or utilization review organization within five working days before the date of the scheduled review hearing except that in the case of an emergency medical condition, such request must be made no less than twenty-four (24) hours of the scheduled review hearing.

(f) The health insurance plan or utilization review organization shall provide the insured a written decision setting forth the relevant facts and conclusions supporting its decision within 72 hours if the appeal involves an emergency medical condition as

defined by K.S.A. 40-22a13(b); 15 business days if the appeal involves a pre-service claim and 30 days if the appeal involves a post-service claim.

(g) For the purposes of this section:

(1) "Health insurance plan" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(2) "Insured" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(3) "Insurer" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(4) "Adverse decision" shall have the meaning ascribed to it in K.S.A. 40-22a13, and amendments thereto.

(5) "Pre-service claim" means a request for a claims decision when prior authorization of services is required.

(6) "Post-service claim" means a request for a claims decision for services that have already been provided.

(h) this section shall be a part of and supplemental to the utilization review act.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

COMMENTS
ON
SB 522—PROVIDING AN INSURED CERTAIN APPEAL RIGHTS
HOUSE INSURANCE COMMITTEE
March 14, 2006

Mr. Chairman and members of the committee:

Thank you for the opportunity to speak with you on behalf of the Kansas Insurance Department. I am here today to support the concept behind SB 522. We believe it is important for insureds to receive coverage for the medical care they need when they need it, so long as the care is within the scope of their health insurance contract.

We see this bill as a way to receive a quicker decision for the insured when they challenge an insurance company's original ruling. In addition we believe it is important to allow the consumer to have legal representation present throughout the appeal process if they so desire.

However, it is important to note that this bill does not say that health insurance companies cannot have a secondary internal appeal process. In fact we believe it is important for the secondary appeal process to continue to be offered—it provides the consumer yet another opportunity for their case to be heard and prevail. What this bill does say, is if a consumer voluntarily wants to forego their right to a secondary appeal, they can.

Mr. Chairman, other conferees have offered balloon amendments to address the changes made by the Senate. I have seen the new language and I urge the committee to adopt the balloon. It is important these changes be made so that this legislation reflects the rules set forth by the U.S. Department of Labor by which all ERISA plans must abide by.

With the new agreed upon language that has been presented to you, we fully support SB 522 and I urge this committee to recommend it favorable for passage. Thank you again for the opportunity to address the committee today and I would be happy to stand for any questions.

Jarrod Forbes
Government Affairs Officer

House Insurance
Date: 3-14-06
Attachment # 4

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

KANSAS MEDICAL SOCIETY
KMS

623 SW 10th Avenue
Topeka, KS 66612-1627
785.235.2383
800.332.0156
fax 785.235.5114

www.KMSonline.org

To: House Insurance Committee

From: Jerry Slaughter
Executive Director

Subject: SB 522; Concerning appeal rights of adverse decisions by health insurers

Date: March 13, 2006

The Kansas Medical Society appreciates the opportunity to appear in support of SB 522, which would establish certain appeal rights for individuals when contesting adverse decisions made by health insurers.

Under current law, an individual who contests an adverse decision made by a health plan on whether a certain service should be covered must first exhaust all the internal review procedures of the health plan before appealing the decision to the external review process afforded them under K.S.A. 40-22a14, *et seq*. Health insurers must have an internal review process in place, but Kansas law does not proscribe what that process must entail. Because the law isn't specific about requirements for internal review, it can vary considerably from insurer to insurer. It can be simple and straightforward, to quite complex for individuals to navigate. SB 522 provides that when a health insurer has a two-level review or appeal process, an individual may waive the right to a second appeal, and go directly to external review, notwithstanding the provisions of K.S.A. 40-22a14(d).

The bill provides further that in the event an individual elects to request a second-level appeal, the individual has the right to appear in person, the right to be represented by counsel or have assistance from a person of the insured's choice, the right to receive and review all relevant documents, the right to submit questions, and the right to record the proceedings of the second-level appeal.

We support these changes in law. Without question, appeals of health insurers' adverse coverage decisions have immense implications for individuals and families. Because so much is at stake in these matters, it makes sense to do everything we can to make sure the process is fair, timely and transparent. The changes contained in SB 522 will not prevent an insurer from making coverage decisions based on their own medical necessity guidelines. It will, however, allow an individual the right to access the external review process earlier in certain cases. It also provides individuals with a greater opportunity to participate in and understand an insurer's internal review process, which has such a key

role in coverage determinations. We believe the proposed changes are reasonable, and we urge your support of this bill. Thank you for considering our comments.

NASW KANSAS CHAPTER
National Association of Social Workers

...the power of social work

March 14, 2006

House Insurance Committee

Good afternoon. My name is Sky Westerlund. I serve as the Executive Director of the Kansas Chapter, National Association of Social Workers (KNASW). KNASW is a membership organization working on behalf of the profession and practice of social work in Kansas.

SB 522 is for the consumer. It outlines, by statute, that an insured person can waive the insurance carrier's second appeal so that the person can then request an external review of a claim that the insurance company has denied. **Persons who pay premiums and believe that their health needs will be paid for through their insurance coverage can experience an unsettling situation when the insurance company rejects their request for a benefit.** This is anguishing for all consumers. It becomes even more anguishing if the insured person must fight the insurance carrier through multiple levels of appeal before all such appeals are exhausted. One must exhaust all means of internal appeal before requesting an external review of the original denial of payment for insurance benefits.

SB 522 allows the consumer the ability to seek an external review after the first appeal of an insurance carrier's denial of benefits by waiving the second appeal. The external review can happen much sooner than currently exists.

KNASW supports SB 522 and encourages your support of the legislation.

Thank you for your consideration of this important consumer focused legislation.

Jayhawk Towers, 700 SW Jackson Street, Suite 801, Topeka, KS 66603-3740
(785) 354-4804 • FAX: (785) 354-1456 • knasw@birch.net • www.knasw.com

KSNA
KANSAS STATE NURSES ASSOCIATION

1208 SW TYLER
TOPEKA, KANSAS 66612-1735
785.233.8638 • FAX 785.233.5222
www.nursingworld.org/snas/ks
ksna@ksna.net

ELLEN CARSON, PH.D., A.R.N.P., B.C.
PRESIDENT

THE VOICE AND VISION OF NURSING IN KANSAS

TERRI ROBERTS, J.D., R.N.
EXECUTIVE DIRECTOR
Terri Roberts J.D., R.N.
troberts@ksna.net

S.B. 522 Health Insurance: Providing the insured certain appeal rights regarding adverse health care decisions.

Written Testimony March 14, 2006

Chairman Shultz and members of the House Insurance Committee, the KANSAS STATE NURSES ASSOCIATION supports S.B. 522 which is designed to give health insured's better access to the internal appeals process for unfavorable decisions affecting services being denied.

This bill provides *quantum leap* changes in the responsiveness of utilization review procedures currently implemented by health insurers. For many years insured's and the provider community as a whole have been frustrated by a lack of accountability by the health insurance industry in responding to decisions, questions and appeals related to unfavorable decisions affecting healthcare.. For RN's and ARNP's in office based settings, this often meant that they were responsible for relaying service denial messages from the insureds utilization review providers. This go-between position for any health care provider is uncomfortable and can be very awkward.

KSNA is offering some additional language changes to consider, mostly technical in nature to insure that the legislative intent is clear. There are three substantive changes that merit consideration:

page 2, line 2, adding the works "or their representative" would provide recourse if the insured was incapable (due to critical illness) to process an appeal.

page 2, line 33, KSNA believes that in some cases there may exist exigent circumstances where "time is of the essence" that warrants a shorter response time, we thought this should be considered as legislative intent to provide an alternative in such cases. We think the pace of technology and pharmacological therapeutics supports such a provision if experimental courses of treatment are being considered, *and lastly*

page 3, line 6, the Senate Floor amendment to add the requirement for "recording the proceedings" is **excellent public policy**, but we question *why the insured is responsible for those costs.* **We support changing this to the "insurance company"**, who will be controlling the logistics and manner of the appeal, it is more appropriate for them to provide the mechanism for recording and absorb those costs as a cost of "doing business".

S.B. 522 will go a long way to provide a fairer, more open and level playing field for health insured's seeking reconsideration of denials by the carrier for covered services. *Thank you for consideration.*

House Insurance
Date: 3-14-06
Attachment # 7

Kansas State Nurses Association
March 14, 2006

7-1

[As Amended by Senate Committee of the Whole]

As Amended by Senate Committee

Session of 2006

SENATE BILL No. 522

By Committee on Financial Institutions and Insurance

2-8

AN ACT concerning health insurance; providing the insured certain appeal rights regarding adverse health care decisions.

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

Section 1. (a) ~~As a part of its health insurance plan, an insurer shall provide to each insured a copy of the insurer's process for utilization review.~~ *Every health insurance plan for which utilization review is performed shall include a description of the health insurance plan's procedures for an insured to obtain internal review of an adverse decision. This description shall include all applicable time periods, contact information, rights of the insured and available levels of appeal.* If the health insurer uses a utilization review organization, the insured shall be notified of the name of such utilization review organization. *The health insurance plan shall provide an insured with written or electronic notification of any adverse decision, and a description of the health insurance plan's review procedure, including the insured's right to external review as provided in K.S.A. 40-22a14 and amendments thereto.*

(b) If ~~an insurer's~~ *the* health insurance plan ~~or process for~~ utilization review contains a provision for two levels of appeal or internal review of a health care decision which is adverse to the insured, the ~~insurer's~~ health insurance plan shall ~~provide written notice to the insured that~~ *allow* the insured ~~may~~ *to* voluntarily waive such insured's right to the second appeal or internal review.

or further

(c) If an insured waives the right to the second appeal or internal review, the ~~insurer's~~ health insurance plan will waive its right to assert that the insured has failed to exhaust administrative remedies because the insured did not elect to submit review of a health care decision which is adverse to the insured to the second appeal or internal review provided by the ~~insurer's~~ health insurance plan ~~and give notice to the insured of the insured's right to external review as provided in K.S.A. 40-22a14 and amendments thereto~~.

or further

Kansas State Nurses Association
March 14, 2006

7-3

(d) If an insured elects to request the second appeal or internal review of a health care decision which is adverse to the insured, the insured shall have the right to appear in person before designated representatives of the ~~insurer's~~ health insurance plan or utilization review organization at the second appeal or internal review meeting. The designated representatives who will be deciding the appeal or internal review shall be present and participate in person, by telephone or by other electronic means. *No physician or other health care provider serving as a reviewer in an appeal or internal review of an adverse decision shall be liable in damages to the insured or the health insurance plan for any opinion rendered as part of the appeal or internal review.*

or their representative

(e) ~~Upon receipt of a request from the insured for the second appeal or internal review meeting, the insurer's health insurance plan or utilization review organization shall send notice to the insured of the insured's right to~~ *All* ~~second~~ *appeals or internal reviews shall provide that the insured has a right to*:

Remove second

(1) ~~Request, within five working days,~~ the opportunity to appear in person before an appeal or internal review panel of the ~~insurer's~~ health insurance plan's or utilization review organization's designated representatives;

(2) receive from the ~~insurer's~~ health insurance plan or utilization review organization, upon request, copies of all documents, records and other information that are not confidential or privileged relevant to the insured's request for benefits;

(3) have a reasonable and adequate amount of time to present the insured's case to the appeal or internal review panel;

(4) submit written comments, *questions*, documents, records and other material relating to the request for benefits for the appeal or internal review panel to consider when conducting the second review meeting both before and, if applicable, at the second review meeting. *Within five business days of the second review hearing date the health insurance plan shall provide a written response to questions submitted in writing by the insured*

or no more than on calender week

exigent circumstances exist, on expedited review may be conducted with a shorter response time established by the hearing officer. During such delay insured shall be provided full contract benefits

(5) ask questions relevant to the subject matter of the appeal or internal review of any representative of the ~~insurer's~~ health insurance plan or utilization review organization serving on the appeal or internal review panel;

(6) be assisted or represented at the second appeal or internal review meeting by an individual of the insured's choice; and

(7) ~~record the proceedings of the second appeal or internal review meeting at the expense of the insured receive a copy of the record of the proceedings of the second appeal or second internal review. Such record shall contain at least as~~

~~*(1) List of all participants and how each participated (whether in person, by telephone or some other means;*~~

~~*(2) summary of the position presented by each party; and*~~

~~*(3) list of all exhibits, documents or other evidence presented.*~~

[record the proceedings of the second appeal or internal review meeting at the expense of the ~~*insurer.*~~*]*

insurance company

(f) An insured, or the insured's authorized representative, wishing to request to appear in person before the second appeal or internal review panel consisting of the ~~insurer's~~ health insurance plan's or utilization review organization's designated representatives shall make the request to the ~~insurer's~~ health insurance plan or utilization review organization within five working days after the date of receipt of the notice sent in accordance with subsection ~~(e)~~ *(a)*.

(g) The ~~insurer's~~ health insurance plan or utilization review organization shall provide the insured a written decision setting forth the relevant facts and conclusions supporting its decision *within five business days of the hearing date*.

(h) For the purposes of this section:

(1) "Health insurance plan" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(2) "Insured" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(3) "Insurer" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(4) "Adverse decision" shall have the meaning ascribed to it in K.S.A. 40-22a13, and amendments thereto.

(i) This section shall be a part of and supplemental to the utilization review act.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

7-4

STATE OF KANSAS

BARBARA P. ALLEN
SENATOR, EIGHTH DISTRICT
JOHNSON COUNTY
9851 ASH DRIVE
OVERLAND PARK, KANSAS 66207
(913) 648-2704
STATE CAPITOL, ROOM 122-E
TOPEKA, KANSAS 66612-1504
(785) 296-7353

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: ASSESSMENT AND TAXATION
MEMBER: EDUCATION
JUDICIARY

March 14, 2006

Mr. Chair, Members of the Committee:

Thank you for the opportunity to testify in support of House Substitute for SB 522, providing the insured certain appeal rights regarding adverse health care decisions. This bill is a "Consumer Bill of Rights", providing people like you and me certain appeal rights in the internal review process in health insurance appeals.

Under current law, Kansas does require health insurance companies to have an internal review process, but we do not stipulate what that process must be. The NAIC has a Health Carrier Grievance Procedure Model Act, parts of which are the basis of this bill. According to information provided by the NAIC, 39 states have enacted either model/similar legislation, or related legislation/regulations. Kansas is one of 11 states that has taken no legislative action in this area.

Ask yourself if you would want the following basic rights to be afforded to you in an appeal hearing, when you or your loved one has been denied health insurance benefits for a critical, expensive, potentially life-saving procedure, such as a stem-cell transplant.

1. The right to appear in person before the appeal panel.

2. The right to have a majority of members of the appeal panel who will be deciding your case present and participating, either in person or by electronic means.

3. The right to receive copies of all records and documents relevant to your request for coverage.

4. The right to have a reasonable and adequate amount of time to present your case to the appeal panel.

House Insurance
Date: 3-14-06
Attachment # 8

5. The right to ask questions and receive answers from members of the appeal panel relevant to the subject matter of the appeal.

6. The right to be represented by an attorney or a physician at the hearing.

7. The right to record the proceedings of the appeal, at your own expense.

8. The right, after being informed of what you are giving up, to waive your second appeal, because time is literally of the essence, and you want to move on to the external review process in hopes of obtaining a favorable outcome.

Today, NONE of these basic rights are afforded the insured. All of the control lies with the insurance companies.

I am proud that Governor Sebelius, Insurance Commissioner Praeger, the Kansas Medical Society and representatives of the insurance industry support House Substitute for SB 522. A Consumer Bill of Rights in the internal review process for insurance appeals is the fair and right thing to do. This bill passed the Senate 40-0. I respectfully ask for your support of House Substitute for SB 522.

Barbara

Barbara P. Allen
Senator, District 8

Testimony to the Kansas House of Representatives Committee on Insurance on SB 522 State Capitol – Topeka, Kansas - March 14, 2006

Dear Representative Schultz and members of the Committee:

My name is Dr. Ira Stamm. I am a psychologist in private practice in Topeka. I am here to share information about utilization review and to argue the case that Senate Bill 522 should be strengthened to provide greater protection for consumers.

I am looking at Senate Bill 522 through three lenses. As a psychologist with the Menninger Clinic in Topeka from 1972 to 1995 and in private practice since then, I see on a daily basis the harm done to clients by utilization review. Utilization review was one of two factors that forced the Menninger Clinic to close its doors in Topeka. Throughout its history Menninger supported patients staying in the Menninger hospital for the amount of time they needed to get well. For some patients this was a few days; for others it was weeks and months; and for a few the time needed for complete recovery was over a year.

Throughout much of Menninger's history insurance companies did what insurance companies are designed to do – they collected premiums and paid claims – and patients obtained the treatment prescribed for them by their doctors. Then in the last twenty years – insurance companies began to intrude into the practice of medicine – and insurance company representatives began to tell licensed physicians and psychotherapists how to do their jobs. "No, doctor – we think the patient does not need that procedure – no, doctor, the patient only needs three days in the hospital – not two weeks – no, doctor – we can only authorize for the patient to see you three sessions at a time."

I am also looking at Senate Bill 522 through the eyes of a survivor of prostate cancer. When I was diagnosed with cancer in 2002 the insurance company told me the good news and bad news. The good news was that my treatment was covered by my wife's insurance plan; the bad news was that should my wife's policy lapse for any reason, I will not be able to purchase health insurance from any company doing business in Kansas. Once any of us in this room has cancer, heart disease, diabetes, etc, commercial insurance will not insure you. Utilization review contributes to underwriting standards. You may have been healthy for ten or for forty years – and paid premiums throughout those years – but once you develop certain illnesses – you are treated by the insurance industry as though you had the plague.

I am also looking at Senate Bill 522 through the lense of a Cycle III Scholar in the Kansas Public Health Leadership Institute. For my graduation paper, I will be examining different models for funding and offering all Kansans health care insurance. Examining utilization review as part of the health care funding debate will be part of my study.

Phases of Utilization Review

The history of utilization review can be divided into three stages. Utilization review came into being to study the discrepancies and variance in the practice of medicine. UR correctly noted that if you were a woman about to give birth in the western part of a given state you were 2 times as likely to deliver your child by Caesarian section then if you lived in the eastern part of the state.

Utilization review helped us to appreciate the following. Until about five years ago if any of us walked into the emergency room with chest pain and were diagnosed with blockage of one or more coronary arteries – there was no long-term scientific outcomes data to tell the doctor whether you were better off having a stent placed in the artery or to undergo cardiac by-pass surgery. Angioplasty and cardiac bypass surgery are multi-billion dollar industries – but for decades there was little science to direct the choices made by physicians. During this era utilization review played the helpful function of providing a second opinion about medical practice.

In the second phase of utilization review – insurance companies addressed the concern about escalating health care costs and increased insurance premiums. Instead of approaching the problem with a finely honed scalpel, the insurance industry took a lumberjack's axe to the problem, drastically reducing fees charged by doctors and hospitals – and they began to deny services to patients left and right without any scientific basis or merit. This was seen most dramatically in mental health.

The second phase of utilization review was effective for several years in limiting the increases in insurance premiums to consumers. If you pay pennies on the dollar for a service and on top of that don't allow the service to occur very often – that service will become less costly or extinct. And that is what the insurance companies have done – especially in the area of mental health.

We are currently in the third phase of utilization review. Most doctors and hospitals practice evidence based medicine – and excess costs and expenses have been wrung out of the health care system.

In the current phase of utilization review – any savings extracted by the insurance company goes to the bottom-line of the insurance company and to shareholders. The CEO of United Healthcare was paid $62 million dollars last year; its subsidiary United Behavioral Health until recently authorized psychotherapy sessions to patients 3 to 6 sessions at a time.

Several years ago I attempted to get a depressed adolescent boy admitted into a Kansas psychiatric hospital for more than 5 days of care. The boy had become agitated and put his hand through the sheetrock at home. The insurance company denied the admission as "not medically necessary" and recommended that I tell the parents to call SRS and have the boy declared "a child in need of care" or to call the police and have him treated within

the juvenile justice system. Utilization review denied this boy's care through his insurance; he eventually did obtain care but at the taxpayer's expense.

It may be that utilization review has outlived its usefulness and can no longer be justified. Some have argued that UR is a form of "bait and switch." Consumers pay premiums for years at a time; when they fall ill and need services the insurance company uses its contrived labyrinth of rules and regulations to avoid having to pay for the service.

Others have likened the UR practices of some insurance companies to that of the school yard bully. UR picks on patients when they are most in need and most vulnerable and when they have little strength and energy to fight the company.

Utilization review has inverted the hierarchy of care in the practice of medicine. It used to be that the patient and doctor – collaborating together as a team – directed the patient's care. Not so any more – it is now the insurance company who directs patient care.

To conclude, I would recommend that Senate Bill 522 be replaced by a shorter bill that reads as follows:

Any procedure recommended or prescribed by a physician or health care professional licensed to practice in Kansas shall be allowed and paid for by the insurance company issuing the policy to the consumer, if the procedure is within the practitioner's scope of practice, and if the procedure is a covered benefit in the policy.

There shall be a presumption of competence on the part of the licensed doctor and health care professional practicing in Kansas. Nonetheless, an insurance company may request of the Kansas Insurance Department that it review the appropriateness of a given treatment or procedure before it occurs. This review will be conducted within 24 hours by the Kansas Insurance Department and the decision of the KID given to the patient, doctor, and insurer.

The only basis for an insurance company questioning a given procedure will be if the insurer presents unequivocal scientific evidence that the procedure requested by the patient and doctor does not conform to currently accepted practice standards, or that the procedure endangers the safety and welfare of the patient.

Thank you for allowing me to share these remarks with you. I would be pleased to answer any questions you may have.

Ira Stamm, Ph.D., ABPP
Board Certified in Clinical Psychology
American Board of Professional Psychology

3600 SW Burlingame Road – Suite 1A
Topeka, KS 66611
913 706-8831
istamm@aol.com

Kansas Association of Insurance Agents

Testimony on Senate Bill 422
Before the House Insurance Committee
By Larry Magill
March 14, 2006

Thank you mister Chairman and members of the committee for the opportunity to appear today in support of SB 422, a measure introduced by the Senate Financial Institutions & Insurance committee at our request. My name is Larry Magill and I represent the Kansas Association of Insurance Agents. We have approximately 425 member agencies across the state and another 125 branch offices that employ a total of approximately 2,500 people. Our members write roughly 70% of the business property and liability insurance in Kansas and 35% of the personal insurance. Independent agents are free to represent a number of different insurance companies.

Senate Bill 422 came about as a result of one of our members being asked for a bridge construction performance bond with co-sureties by a county attorney. The attorney had actually bothered to read the statute and it requires co-sureties with no option. Co-surety arrangements are generally used to allow two sureties to share the risk on extremely large projects, which this was not. This was a bridge project under KSA 2006 Supp 68-1402.

The agent involved, which is a large regional agency that handles a lot of construction bonds, was not able to convince any of their surety companies to share the risk on a small bridge project. The agent finally convinced a sister company of the contractor's surety to co-sign on the bond and technically satisfy the statute. But it required a great deal of unnecessary work on the agent's part and provided no value to the county.

When we discussed the issue with the Insurance Department, they researched the statutes and came up with seven instances where the statutes call for co-sureties and drafted the bill before you. In the end, they decided not to introduce the bill but support our introduction. On further study many of these statutes appear to have been set up for personal sureties, as opposed to corporate sureties. Personal sureties are individuals willing to pledge their personal assets to back someone else. Corporate sureties are insurance companies licensed to write surety bonds.

We are not aware of any personal suretyship that is going on today. It was something that was done frequently before there were corporate sureties but that was many years ago.

We view this as a simple clean up of archaic statutes and urge the committee to pass the bill favorably. We would be happy to answer questions or provide additional information.

House Insurance
Date: 3-14-06
Attachment # 10

,0 S.W. Jackson Street, #1408
Topeka, Kansas 66612-2214
(785) 235-1188 • Fax (785) 235-2544

KAPA

Kansas Aggregate
Producers' Association

Edward R. Moses
Managing Director

TESTIMONY

Date: March 14, 2006

Before: The House Committee on Insurance

By: Edward R. Moses, Managing Director
Kansas Aggregate Producer's Association

Regarding: Senate Bill 512 Silicosis Claims

Good Afternoon Mr. Chair and Members of the Committee:

My name is Edward Moses, Managing Director of the Kansas Aggregate Producer's Association. The Kansas Aggregate Producer's Association is a group of approximately 200 stone, sand and gravel producers and their suppliers located throughout the state of Kansas. We appreciate the opportunity to appear before you today in support of Senate Bill 512 a very important matter to our industries as well as many others. As with other matters that come before this committee as well as the legislature in general, the question surrounding silicosis claims is an issue of developing appropriate state policy in order to assure that a fair and reasonable outcome is achieved.

What is Silicosis?

Silicosis is a respiratory disease caused when minute particles of silica, usually associated with industrial sandblasting operations; becomes imbedded in the lung. It is important to note that silicosis is not related to asbestos a similar lung disease caused by asbestos particularly in the fact that silica, despite many years of study has never been found to be carcinogenic. In Kansas our rock, sand & gravel actually contain very low amounts of silica as a matter of fact so low that in some cases they are not measurable and according to the National Institute of Occupational Safety and Health (NIOSH) exposure to silica in mining operations is low. However, this has not prevented the Kansas aggregate industry from getting embroiled in what has become a national silica debate.

The Problem

Often when matters such as these come before the legislature, the question is often asked what has changed, why are we having this problem today which we did not have before? In this particular case the problem has developed over the last 12 to 24 months where many small producers have seen insurance coverage for silicosis claims excluded on general product liability policies. The reason for this has been an explosion of silica cases, primarily aimed at producers and users of industrial sand, which has led insurance carriers, concerned about equally explosive defense costs, to exclude silicosis coverage no matter where a particular producer may reside and how a producer may operate. Despite the fact that the overall national mortality rate for silicosis has been dropping steadily for the last 40 years. In fact NIOSH reports that over the last thirty years, the number of silica-related deaths has dropped nearly eighty-four percent, from 1,157 in 1968, to 187 in 1999. To put the NIOSH figures in context, the U.S. Centers for Disease Control and Prevention (CDC) report that, on average, 400 people in the United States die each year from extreme heat. In Kansas this has become a particularly acute crisis for our industry as the Kansas aggregate industry is comprised of a high percentage of relatively small family owned businesses, firms who due to their size do not have a net worth to withstand the defense costs associated with a silicosis claim or pay out awards on potential silica claims. Without insurance coverage, to spread the risk, it is virtually impossible to withstand such an action without facing bankruptcy. At this point, it should be noted this is an even larger threat for both state and local governments who use industrial sandblasting in routine road and bridge maintenance.

The Solution

SB 512 is similar to measures that have been passed in Georgia, Florida, Texas and Ohio providing a statewide policy that would establish reasonable standards on the circumstances under which a silica claim could arise. The peanut of this bill requires that any potential third party wishing to make a silicosis claim against a producer would have the duty of providing bona fide medical diagnoses, using American Medical Association (AMA) guidelines; prior to the filing claim. Roughly similar to requirements currently found in workers compensation law. It is hoped by providing such a requirement that in Kansas we may avoid a situation in Texas where over 11,000 silicosis claims were filed by parties alleging to have mere exposure to the disease rather than providing a verified medical diagnoses of silicosis.

The Need

At the close of this hearing you will begin the task of due deliberation and take some form of action. As you go about this process please bear in mind there are many communities involved in this issue. First, are those with a legitimate silicosis diagnosis, they should have a reasonable assurance funds will be available for the settlement of their just claims. They should not be forced to compete with many thousands making potential exposure allegations. Second, are the employees, the families, the retirees and many others who depend upon the financial stability of the firms of which they are associated As the Enron collapse illustrated, bankruptcies represent more than the demise of a business. They can cost employees their jobs, retirees their pensions and ordinary citizens their savings, as well as have a deep impact on entire communities. Finally, the citizens of Kansas, who as taxpayers, must bear the costs if sued for maintenance operations.

Through passage of this law the legislature will take a positive action towards providing an environment in which insurance coverage for silicosis claims can be restored, protect small producers from the threat of bankruptcy and yet maintain responsible coverage in order that those claimants with legitimate diagnosis of silicosis can be assured that responsible parties with have the actual means to pay their claims. With this in mind we would ask this committee to take due diligence in your deliberations and recommend SB 512 favorably for passage.

Thank you for taking the time to hear our comments and I will stand ready to answer questions at the appropriate time.

Wall St. + Journal
Saturday, 6 11, 2006

Trial Bar Cleanup

It's amazing what a little courage from the bench can do to clean up the justice system. Now that word is out that most silicosis lawsuits are shams, ever more judges are helping to expose the corruption.

The latest is Florida state Judge David Krathen, who in a recent hearing rebuked plaintiffs lawyers for inventing silicosis suits, and declared "mind-boggling" the effect that phony suits were having on the "economic well-being of this country." He vowed to ride herd on the claims in his court, separating the good cases from the fake.

'Reeks from fraud' ... 'bilking our society.'

This isn't the way trial lawyers are used to being treated, and credit for this tougher approach goes in part to Texas federal Judge Janis Graham Jack. Judge Krathen made specific reference to the litigation Judge Jack presided over last year, in which she exposed how lawyers, doctors and X-ray screening companies had "manufactured" some 10,000 bogus silicosis suits "for money."

Of the 10,000 suits that Judge Jack sent back to state courts, more than half have already been dismissed—often at the request of the lawyers who first filed them. Even the wizards of the plaintiffs bar are wary of re-entering court sporting discredited doctors and screening companies, many of which are now the focus of federal and Congressional investigations. Separate silicosis suits have also been dismissed in Ohio.

Those plaintiffs attorneys who continue to roll the dice are having to resort to ever more desperate practices. In the Florida case, lawyers rushed to file most of their claims the day before a new state statute curbing asbestos and silicosis suits took effect. They also filed all 111 in Broward County, which is notoriously friendly to the trial bar—or at least it was until they met Judge Krathen, a former trial attorney himself.

The judge allowed defense attorneys to present what they'd uncovered so far about those 111 claims. The stunner was that 72% of the plaintiffs had filed both asbestosis and silicosis suits—despite the medical rarity of having both ailments. Defense lawyers also noted that one of the X-ray screening firms (N&M) singled out in Judge Jack's courtroom also had a role in the Florida suits.

When a trial lawyer defended the practice of driving mobile X-ray vans to do mass screening, Judge Krathen cut him off, noting that N&M "reeks from fraud." He went on to say: "I'm offended, and I've practiced law for 30 years and now on the bench for three years, that lawyers resort to drive-up buses or vans, unmarked, to sit there, and it looks like . . . are involved in bilking our society and our institutions out of money for no valid reason."

The judge has since ordered the trial lawyers to pony up fact sheets about their clients. These questionnaires are arguably the most detailed a judge has ever requested in such a suit, demanding not only exhaustive information about plaintiffs' diagnoses, but specifics about any prior asbestos lawsuits.

Judge Krathen also took aim at the plaintiffs lawyers' scattershot approach to naming defendant companies—80 in all—and demanded that their clients start identifying specific products that supposedly caused them harm. This was after a lawyer representing a construction-related firm called Vulcan Materials told the judge that while his company had been named in 17,000 claims, its products had only been positively identified by plaintiffs in 23. The lawyer estimated it can cost Vulcan up to $17,000 to get dismissed from a case.

The judge summed things up this way: "In the years I've practiced law, the toughest time was getting a good legitimate case bought into by the jury because of all the horrible publicity that comes out from the negative kind of stuff that goes on in [the Jack suit]. . . I'm concerned about the good clients, the good cases, and I'm concerned about the economic well-being of our economy and our companies that support jobs here in the U.S. . . I want this information [about patients and products] up front."

That's the sort of fair-minded approach that has unfortunately been missing from judges in the many years that the asbestos and silicosis blobs have been destroying honest companies and clogging courtrooms. It's good to see a few more judges standing up to the trial bar's transparent corruption.

11-4

Kansas Aggregate Producers' Association
SB512

An illustration:

Assume average cost of defense is $8,500 ($17,000 / 2):

For Vulcan Materials, a limestone producer in Tennessee:

$8,500 X 17,000 = $144,500,000

For a Kansas producer (assume 200 claims):

$8,500 X 200 = $1,700,000

March 7, 2006

Legal Affairs

Silicosis Ruling Could Revamp Legal Landscape

by Wade Goodwyn

Dr. Jay Segarra is an X-ray reading specialist known as a "B-reader" who has diagnosed thousands of plaintiffs in asbestosis litigation.

DOUBLE DIAGNOSES: In November 2004, Segarra diagnosed one patient, John Netter, with silicosis. Six months later, in May 2005, he diagnosed Netter with asbestosis. Segarra's later report noted that the patient had "no rounded opacities in the upper lung zone to suggest the presence of silicosis."

- November 2004: Segarra diagnoses Netter with silicosis
- May 2005: Segarra diagnoses Netter with asbestosis

Related NPR Stories

- PART TWO: Listen to the second part of this story

"These diagnoses were driven by neither health nor justice: They were manufactured for money."

All Things Considered, March 6, 2006 · In a packed Texas courtroom last year, a federal judge accused doctors and lawyers of legal and medical fraud.

Silicosis is a deadly lung disease that industrial workers get from inhaling crystalline silica in foundries, mines, quarries and shipyards. Over the last few years, plaintiff lawyers aggressively advertised for silicosis victims, inviting them to mass medical screenings. As a result, state and federal courts were inundated with tens of thousands of silicosis claims.

But the lawsuits hit a major roadblock in Corpus Christi, Texas, when a judge warned a testifying doctor that he might want to get a lawyer before he said anything further. U.S. District Judge Janis Jack ruled that thousands of silicosis claims had been manufactured for money. Her ruling is having an impact on hundreds of thousands of asbestos and silica claims across the country.

A Sudden Avalanche of Litigation

Clean white sand -- the nemesis of golfers, the delight of young children -- goes into paint and glass and a thousand other products you'd both guess and wouldn't. But it can also kill you. Microscopic bits lodge in the most delicate and vulnerable places in your lungs and cause a terrible disease called silicosis. The disease is irreversible and progresses even when exposure stops. Beginning in the 1930s, silicosis cut a nasty gouge out of America's working class. In one notorious case, at least 764 workers died of the disease during the construction of Hawk's Nest Tunnel in West Virginia in the early '30s.

It took half a century, but government regulations eventually began to reduce the incidence of silicosis in the 1970s. So it was quite a surprise to John Ulizio, the CEO of U.S. Silica, when Fed Ex began pulling up to his company's building every day in the winter of 2002.

"The Fed Ex man started to show up with all of these lawsuits," Ulizio recalls. "In November of 2002, and running for a couple months after that date, we were inundated with over 20,000 new claims, by new people, almost all of which were in Mississippi, claiming that they had silicosis."

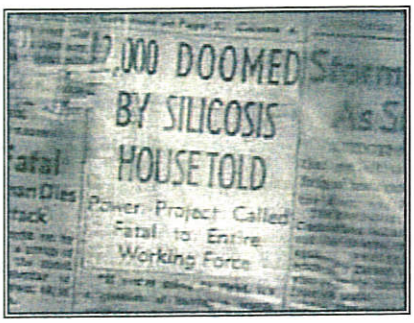
This was a disaster, maybe the end of U.S. Silica, the largest manufacturer of sand in the country. Were there going to be 20,000 more lawsuits in the next quarter? What in the world was happening in Mississippi?

"We kind of scratched our heads and figured, 'What the heck's going on down

Judge Janis Jack, in her 250-page opinion in the case

there?'" Ulizio says. "We kind of knew, almost as a matter of course, that they weren't real cases. Because, if you look at the federal CDC data on silicosis, there was no indication in the disease prevalence data that there was all of a sudden an epidemic of silicosis."

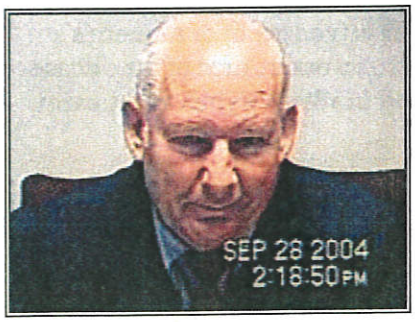
WEB EXTRA: Silicosis Threat



In the 1930s, silicosis posed a serious public health threat to America's workers. In one notorious incident in West Virginia, at least 764 workers died from the disease during the construction of the Hawk's Nest Tunnel. But workplace safety recommendations adopted in the aftermath helped drastically reduce the disease's toll on the working class. So how did silicosis become a target for massive litigation seven decades later? Wade Goodwyn explains.

- March 6, 2006

Read 'Silicosis: From Public Menace to Litigation Target'



The country's most prolific B-reader, Dr. Ray Harron is responsible for 76,000 legal claims. Harron appeared in court as an expert witness, but at one point, Judge Jack suggested that the doctor stop talking and obtain a lawyer.

A Hidden Epidemic or Reaction to Tort Reform?

It was unprecedented. Suddenly, more silicosis cases were filed on single days in Mississippi than had previously been filed in an entire year. If true, it was evidence of one of the worst industrial disasters in American history. Yet no Mississippi public health officials were ever alerted, and no public health warnings ever issued. What was going on? The reason for this sudden legal activity was new tort reform laws that were being drawn up in the U.S. Senate and had already passed in Mississippi. Before the new laws kicked in, plaintiff lawyers rushed to file their cases. In the fertile ground of Mississippi's industrial Gulf Coast, lawyers began advertising for potential silica plaintiffs.

One television ad features a screen with the words "Silica Testing" in large type. Then a list of occupations begins to scroll: sandblasters, industrial painters, shipyard workers, brick masons, plumbers -- 19 different professions that qualified someone as a potential silicosis victim.

Delford Zarse, a plumber in the twilight of his career, says the ads were enough to make him pursue a silicosis claim. "I was talking to some guy who'd done this, and he said he'd collected quite a bit of money, and I see these ads in the paper, so I signed up," he says.

Before there were mass screenings for silicosis, there were mass screenings for asbestosis: That's how it all started. At first, the screenings targeted professions where workers were likely to have been exposed. But then, some plaintiff lawyers began going from town to town, advertising to and screening the general population. Turnout was good and thousands of new claims were generated this way -- including Zarse's claim. He says he's not sick, but he has been a plumber for 40 years. He went to an asbestos screening and was examined by a specially trained doctor hired by the lawyers. A few weeks later, Zarse got a letter: His X-ray had come back positive.

Zarse had 12 claims. Checks sometimes showed up in the mail, minus 40 percent for his lawyer. He got $11,000. Zarse smokes two packs of cigarettes a day and says he almost never gets sick. He has mixed emotions now about his lawsuit. On the one hand, he likes the money he got. "Anybody gives you money for nothing, you're crazy if you don't take it," Zarse says. But his conscience bothers him, too. "I think it's a rip-off of the companies," he says.

Screening Machine Shifts Course

The mass screenings are the heart of the controversy.

"Most of these people didn't go to their doctor first and get a diagnosis of silicosis, then go find a lawyer. They went to a screening and got a lawyer first," says Fred Kurtz. He's a Mississippi lawyer representing the defendants: sand producers, respirator and

A still from a television ad featuring Heath Mason, CEO of N&M, one of the largest asbestosis and silicosis screening companies in Mississippi. The company used TV ads like this one to find potential plaintiffs in silicosis lawsuits.

- **Watch the Ad**

"A golfer is more likely to hit a hole-in-one than an occupational medicine specialist is to find a single case of both silicosis and asbestosis. N&M parked a van in some parking lots and found over 4,000 such cases."

Judge Jack

Judge Janis Jack's 250-page opinion in the case accused plaintiff doctors and lawyers of "assembly line diagnosing" and suggested diagnoses were being "manufactured for money."

mask makers, and equipment manufacturers. In response to the flood of lawsuits, these companies went to their Republican allies in Congress for relief. Sen. Orrin Hatch (R-UT) began drafting new legislation that, if passed, would put plaintiff lawyers out of the asbestos business for good. And that unhappy prospect inspired some plaintiff firms to switch horses midstream. Instead of asbestos litigation, they'd concentrate more on silica lawsuits. Defense lawyer Danny Mulholland says in Mississippi, the well-oiled screening machine never missed a beat.

"It was the same plaintiffs' lawyers involved, the same doctors involved, the same screening companies -- in many instances, the same plaintiffs," says Mulholland. "What you saw was a shift in diagnosis from asbestosis to silicosis. "

All of a sudden, silicosis claims in Mississippi began going through the roof. And the heart of these lawsuits is the diagnoses of the doctors hired by the lawyers. It is these so-called litigation doctors who are at the center of the controversy.

The 'Litigation Doctors'

Dr. Jay Segarra is a pulmonologist, which means he specializes in lung disease. He says he spent the first 15 years of his medical career serving his country in the Air Force. He fell into X-ray reading in Biloxi, Miss., in 1991 after his discharge. The work started slowly but then really picked up steam in the mid-'90s. Doctors like Segarra are X-ray reading specialists called "B-readers." There are just a few hundred across the country, but the most prolific are responsible for a stunning number of lawsuits. For example, Segarra has diagnosed 29,000 claims of asbestosis. Defense lawyers say he's made thousands of silicosis diagnoses, too.

"Yes, I may have diagnosed that many cases -- and I don't know if I have or not," Segarra says. "But they don't know how many that I've looked at and haven't found any disease."

Reading lung X-rays for evidence of asbestosis or silicosis is not a perfect science. In some cases, an X-ray one doctor might read as positive, a different doctor might read as negative. Segarra says that in spite of his prodigious numbers, his diagnoses have always been done in good faith.

"I'm certainly not a schemer at all," Segarra says. "But am I opportunistic? I suppose I am. But everybody is."

Segarra estimates he has made about $10 million doing this work. When called to testify, he parries cross-examinations with skill. But the Mississippi lawsuits have brought an unusually intense scrutiny. That's because the silicosis defendants decided to fight. The cases were assigned to a federal judge who ordered that the medical and exposure history on *every one* of the 10,000 silicosis claims be turned over to the defense lawyers. That was unprecedented: Usually the court investigates only a sample of the claims. Armed with that information, the defense lawyers also did something surprising. Defense lawyer Mullholland says they ran the silicosis plaintiffs'

- Full Text of Judge Jack's Opinion (Requires Adobe Acrobat)

social security numbers through the nation's largest asbestos databank.

Retread Patients

"When Dr. Harron first examined 1,807 Plaintiffs' [X-rays] for asbestos litigation (virtually all done prior to 2000, when mass silica litigation was just a gleam in a lawyer's eye), he found them all to be consistent only with asbestosis and not with silicosis. But upon re-examining these 1,807 MDL Plaintiffs' [X-rays] for silica litigation, Dr. Harron found evidence of silicosis in every case."

"If you only knew about John Doe who was diagnosed on February 15th you might know everything there is to know about John Doe," Mulholland says. "But the complexion of that information changes when you know there were 110 people who walked through the same door, on the same day, to the same doctor that John Doe did."

It was a eureka moment. It turned out that 68 percent of the 10,000 claimants had previously filed asbestos claims. Pulmonary experts say the number of people known to have developed both silicosis and asbestosis is infinitesimally small. But here were thousands of victims with both diseases. When Segarra is presented with evidence that he has diagnosed the same person with asbestosis one time and then silicosis the next, he says he's not surprised.

"I have looked at thousands of X-rays and made thousands of diagnosis," Segarra says. "If I did not have at least one person like this, then there's something wrong.

"The nature of the science itself is imprecise. You cannot get around that."

Defense lawyers call these cases "retreads" -- people with previous asbestos claims who are later reinvented as silicosis victims, or vice versa. We showed Segarra one of his retreads -- two reports, nine months apart, on the same man. The first time, Segarra diagnosed the man as having silicosis. The second time he said the man had asbestosis. And in his second report, he wrote that he found *no evidence* of silicosis. Segarra didn't realize he was diagnosing the same man twice. Plaintiff lawyers send him thousands of X-rays a year. But what did this plaintiff have --silicosis, asbestosis, both or neither?

"It's impossible for me to say, all the factors that went into these two diagnoses being different," Segarra says. "You can certainly pick out single cases which don't look good, like this one: I've made a total different X-ray diagnosis from one point to the other. But what you will not find is a systematic switch over a large number of cases. You will not find that in my files."

Defense lawyers say they have evidence that Segarra made scores of mistakes like this. Other B-readers made these mistakes, too: One doctor has thousands of these so-called retreads. For 15 years, these mass screenings have provided plaintiff lawyers, defense lawyers, doctors and screening company executives a handsome living. But it all started to come to apart when a federal judge in Corpus Christi was randomly assigned thousands of the silicosis claims from Mississippi.

A Judge with a Nurse's Instincts

U.S. District Judge Janis Jack is a bridge-playing, whiskey-drinking Clinton appointee in Texas. But it wasn't Jack's politics that defined her approach to these silicosis cases: it was her medical background. Before she became a judge, Jack had been a nurse. The more she learned about the screening process, the more her alarm

bells went off. So she ordered that depositions take place in her courtroom, and she did a lot of the questioning herself. NPR has exclusively acquired the courtroom audio. In one exchange between the judge and Heath Mason, CEO of N&M, one of Mississippi's big screening companies, Jack asked him where all the people being screened were coming from. "From what I know, a lot of, some of their initial silica people were their existing asbestos people," Mason told her, saying the patients were re-screened for silicosis.

"We were set to do mass screenings," Mason said in court. "I mean, that's what we did. And from a business standpoint of mine, we had to do large numbers. "

Mason's screening company's rates for testing people positive for silicosis approached 90 percent. His staff, not doctors, took perfunctory work and medical histories. And with some of his biggest clients, it behooved Mason to have a high rate of positive X-rays, because those lawyers only paid him for positive results -- $750 for each. Through his lawyer, Mason declined to comment for this story.

From Expert Witness to Possible Defendant

But it was the doctors' depositions that produced the most fireworks. The country's most prolific B-reader is a doctor named Ray Harron from West Virginia. Harron is responsible for 76,000 legal claims. His reputation began to crumble in Jack's court when defense lawyers started producing evidence of double diagnoses. In one courtroom exchange, excerpted below, a defense lawyer asked Harron how it was possible that his asbestos diagnosis of a man named Kimball seemed to disappear eight years later, when Harron diagnosed Kimball with silicosis.

LAWYER: "And those scars over time, are going to get worse, right?"

HARRON: "Right."

LAWYER: "And as a matter of fact, you said that somebody with those fibers and scars in their lungs are gonna go to their grave with them, right?"

HARRON: "Right."

LAWYER: "Not Mr. Kimball."

The defense then displayed a later set of X-rays. In these films, Kimball now has silicosis, but his asbestosis has cleared up. Judge Jack pressed Harron to explain. She asked, "So now his asbestosis is gone?"

HARRON: "Well, I can't say that it's gone, your honor."

JUDGE JACK: "Well, where'd it go?"

HARRON: "Like I say, I don't know."

Harron offered an explanation: Perhaps the film contrasts were different. But defense lawyers have plenty of examples of Harron's double diagnoses. As they produced the evidence, the doctor's situation on the stand became precarious. He took the stand as an expert witness, but it became clear that his answers could result in his prosecution for fraud. At one point, the judge stopped defense lawyer Mulholland from questioning Harron, suggesting that the doctor should stop talking and obtain legal representation.

Under questioning, the reputations of other B-reader doctors were damaged also. One withdrew hundreds of his silicosis diagnoses, saying he never meant for them to be considered actual diagnoses. By the time the depositions were over, Judge Jack was appalled to find that 6,800 of the 10,000 silicosis claims also had asbestos claims. But

Jack found that the chances of any one person having both diseases were about the same as a golfer making a hole in one. She said that Harron's testimony raised "great red flags of fraud." The judge wrote a 249-page ruling throwing out the testimony of doctors, sanctioning the lawyers and discrediting the mass screenings. Her conclusion? The 10,000 silicosis claims were "manufactured for money."

A Ruling with Far-Reaching Implications

Brent Coon disagrees with much of Jack's ruling. He's a plaintiff's lawyer for some of the silicosis cases in her court. "Judge Jack, she's a fine judge," Coon says. "But I don't think she's very sophisticated about the process. I think this was the first time she'd actually had these complex mass tort cases in her courtroom."

Coon concedes there were problems with some of the diagnoses in the silicosis cases and says Jack properly weeded those out. But Coon says screenings help save workers' lives by alerting them to possible lung illness earlier than they might otherwise have known.

"She discredited some of the doctors involved, but I don't think it's an indictment of the entire process," Coon says. "The process is very good, the concept is very good. Whether or not it's abused from time to time is something that can be controlled and should be controlled."

Coon says it would be an injustice to use the Mississippi cases to try to strip away workers' legal options. Judge Jack's ruling has become a rallying cry for corporate America, the editorial board of *The Wall Street Journal* and the U.S. Chamber of Commerce. Coon says big business wants to use the judge's opinion to create a permanent legal handicap for poisoned workers.

"Those companies knew for decades that those products crippled people and killed people. They knew it," Coon says. "We've got all the documents, all the internal memo, all the depositions that prove that. And it's a shame that now they're able to isolate a few example cases and try to turn that around."

Without question, there are hundreds of industrial workers across the country acutely ill with silicosis. Even the defendants concede that is true. But instead of standing out, their lawsuits float along, jumbled together with thousands of claims generated from mass screenings, clogging court dockets and delaying their opportunity for relief. Time is not on their side.

Judge Jack's methods of deposition and her ruling are beginning to have an impact around the country. In Florida, a judge has ordered silicosis plaintiff lawyers to produce detailed medical information on their claims. In Ohio, a state court handling 35,000 asbestos claims and 900 silica claims is considering calling hearings to depose the doctors the same way Jack did. And on Capital Hill, the House Subcommittee on Commerce and Energy begins its investigation into the Mississippi lawsuits. Like a little legal pebble, the opinion of the nurse who became a federal judge is sending out ripples of change across the nation's court system.

Anne Hawke produced this report.

- March 6, 2006
Federal Judge's Ruling Could Affect Silicosis Cases

LAW OFFICES OF
FRIEDEN, HAYNES & FORBES
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS

JOHN C. FRIEDEN P.A.*
RANDALL J. FORBES P.A.
KEVIN M. FOWLER
CLINTON E. PATTY
TERRY A. ILES
B. LANE HEMSLEY

OF COUNSEL
WILLIAM G. HAYNES*

555 SOUTH KANSAS AVENUE, SUITE 303
P. O. BOX 639
TOPEKA, KANSAS 66601-0639

TELEPHONE: (785) 232-7266
FAX: (785) 232-5841
EMAIL: patty@fhflawfirm.com

*ALSO ADMITTED IN MISSOURI

TESTIMONY
By
Clinton E. Patty

Before the
House Insurance Committee
Regarding SB 512

March 14, 2006

Chair Shultz, members of the committee, my name is Clint Patty. I am an attorney with the law firm of Frieden, Haynes and Forbes in Topeka, Kansas, and am here representing my client, the Kansas Aggregate Producers Association (the "Association") both as counsel and a member of the Association. I have been asked to provide testimony in support of SB 512.

While opponents have concentrated on a few sections of SB 512, the Association believes this committee should not lose sight of the bill's primary purposes: 1) to help resolve the insurance liability dilemma faced by Kansas businesses regarding potential silica claims; and 2) to prevent the kind of wide spread legal abuse that can result from silicosis litigation ***before*** it arrives in Kansas. SB 512 accomplishes these goals while insuring that legitimately harmed claimants will have an opportunity to fully pursue litigation.

The KTLA begins its opposition by citing a lack of silica litigation in Kansas as support for rejecting SB 512 as a, "fix looking for a problem". This view overlooks one of the primary concerns addressed by the bill, the inability of Kansas business to obtain liability coverage for silica claims. It also assumes the Legislature should have no role in taking preventive steps before a potential problem becomes a crisis. SB 512 represents good public policy because it addresses a current problem (lack of insurance coverage for silica claims) and prevents future litigation abuse.

The KTLA next criticizes portions of SB 512 that it argues will raise constitutional and/or procedural problems for potential silica claimants. However, the Association is unaware of any successful Constitutional challenges to similar legislation in other states. Notwithstanding, the specific concerns raised by the KTLA are fully addressed when viewing the bill as a whole.

House Insurance
Date: 3-14-06
Attachment # 12

Contrary to the KTLA's position, there is no concern regarding a claimant's difficulty in obtaining employer records, because SB 512 does not require such records to demonstrate a physical impairment. The bill merely requires that a "competent medical authority" take a detailed occupational and exposure history "***from the exposed person***", not the employer. Sec. 2(b)(2)(A). Therefore, to meet the initial requirements, a medical opinion need only rely on information supplied by the claimant. Significantly, even if a claimant is unable to meet the initial requirements under the law, a judge is only permitted to administratively dismiss the lawsuit *without prejudice*, and the Court retains jurisdiction to reinstate a case when the requirements are met. Sec. 4(c). This protection insures that potential claimants will have other opportunities to pursue their claims even if they can not meet the initial requirements within 60 days of filing a lawsuit.

The Association also believes Section 1(i) of SB 512 has been grossly misrepresented. Opponents claim this section prohibits a treating physician from relying on any other report or medical opinion in diagnosing a potential claimant. However, Section 1(i) only prevents reliance on another report or opinion if:

1. a testing or screening that generated the opinion or report violated the law, regulation, requirement or medical code;
2. it was conducted without a clearly established Dr.-patient relationship with the claimant; or,
3. the report or opinion required the claimant to agree to legal representation prior providing the report or opinion.

This section is designed to prevent the abusive "screening panels" that were exposed by Judge Jack in Texas. Contrary to the KTLA's opinion, nothing prevents a competent medical authority from relying on another medical professional's findings or report so long as it does not violate the above provisions.

I hope this testimony provides some clarification on the issues raised in opposition to SB 512. The Association urges passage of SB 512 as a responsible, preventative response to the concerns raised by Kansas businesses who cannot obtain liability coverage for silica based claims.

Thank you once again for allowing me the opportunity to provide my client's position on this important matter.

CONSIDER IT DONE

TESTIMONY

By the
Mark Wilkerson
Vice President
IMA of Kansas, Inc.
Wichita / Topeka / Overland Park

Before the
House Insurance Committee

Regarding SB 512
An Act Enacting the Silicosis Claims Act

March 14, 2006

Mr. Chairman and members of the committee my name is Mark Wilkerson with IMA of Kansas, Inc. headquartered in Wichita, with offices in Topeka and Overland Park, KS. We are a member of the Kansas Aggregate Producers' Association. I would like to take the time to thank you for allowing me to appear before you today in support of SB 512.

IMA of Kansas is an employee owned insurance and surety bond broker with three locations in Kansas; we also have offices in Denver, Dallas, and Boston. A majority of our 400 plus Associates live and work in Kansas. One of our risk management areas of specialization is in the construction industry which includes working with firms that produce aggregates for building roads, manufacturing cement and redi-mix, and for the construction of buildings and other structures like dams and bridges. We thank you for the opportunity to come before you today to express our support for SB 512, regarding silicosis claims.

While this is an important issue for the insurance industry I want to make it clear that this proposed Senate Bill 512 does not affect Workers Compensation insurance nor the coverage of Kansas workers, it is a bill that is related to the commercial general liability insurance policy.

As result of numerous lawsuits over the past several years and many of these being filed without merit the insurance industry has spent a considerable amount of time and money defending their insured's interests in cases where no evidence of bodily injury has occurred. Plaintiffs have even alleged that possible exposure to silica or mixed dust might create future medical conditions or ailments and are seeking judgments where no injury has occurred. The defense of these unsubstantiated claims has caused the insurer's to look for ways to mitigate their defense expenses.

We are now seeing insurance carriers, large national carriers and smaller regional carriers, apply exclusion for Silica and Mixed Dust to the Commercial General Liability (CGL) policies of many construction firms, quarry operations, manufacturing, glass plants, and tool makers. In addition to the exclusion being applied to the (CGL) the exclusion is also being applied to Environmental

House Insurance
Date: 3-14-06
Attachment # 13

P: 785.232.2202
F: 785.231.2680
www.imacorp.com
AFFILIATIONS: ASSUREX | INTERSURE

IMA of Kansas, Inc.
1631 SW Topeka Blvd.
Topeka KS 66612-1839
dba IMA of Kansas Insurance Services
California Lic # 0D28748

Pollution policies as well. This exclusion releases the carrier from being obligated to respond to claims and be responsible for defense costs, judgments, or settlements related to silica or mixed dust related claim. An extremely narrow exception to the exclusion is becoming available for certain types of industries with large deductibles ($100,000 or more) on a very limited basis.

According to research provided by the National Institute of Occupational Safety and Health, silica or mixed dust related claims in Kansas appear to be extremely low if there are any at all. With this in mind Kansas businesses are being penalized with regards to this exclusion with little to no risk based upon litigation taking place in other parts of the country.

With this exclusion in place, Kansas companies are now on their own to defend themselves against claims or actions whether they have merit or not. Since Kansas aggregates are primarily limestones based and have been found to be extremely low in silica content, compared to states with granite based aggregate with higher amounts of silica present, our businesses face defending themselves against these types of claims with very little likelihood of a silicosis condition being documented.

Several states including Texas, Ohio, Florida and Georgia have enacted legislation to enact preemptive legislation that creates criteria to protect the rights of those who have valid medical symptoms and limit the ability of those who have no medical conditions or evidence to substantiate silica or mixed dust claim.

We are hopeful at IMA of Kansas, Inc., as an insurance broker, that if Kansas adopts a position similar to Ohio, insurance carriers will recognize that silica and mixed dust litigation frequency would be limited to only valid medically documented cases. With this in mind a broker would be able to substantiate a request for the deletion of this exclusion. Carriers would be able to apply their rating schedules against these types of risks and provide the option of coverage for an appropriate premium.

Without this option Kansas Businesses will have to respond to allegations without the benefit of a risk transfer product such as a commercial general liability insurance policy.

If the Kansas Legislature passes this proposed legislation it will limit litigation to only silica and mixed dust claims meeting the established medical criteria and will eliminate the potential for unfounded claims tying up our courts. It will also ensure that those who have valid claims are provided an opportunity to seek medical care and any damages related to their condition from the responsible party.

In closing, we appreciate the opportunity to appear before you. We urge this committee to recommend this bill favorably for passage. I would be willing to answer any questions you may have at the appropriate time. Thank you.

NIOSH Publication Number 2004-146

Worker Health Chartbook 2004

<< Back to Previous Page Chartbook Home Page

Figure 2-197

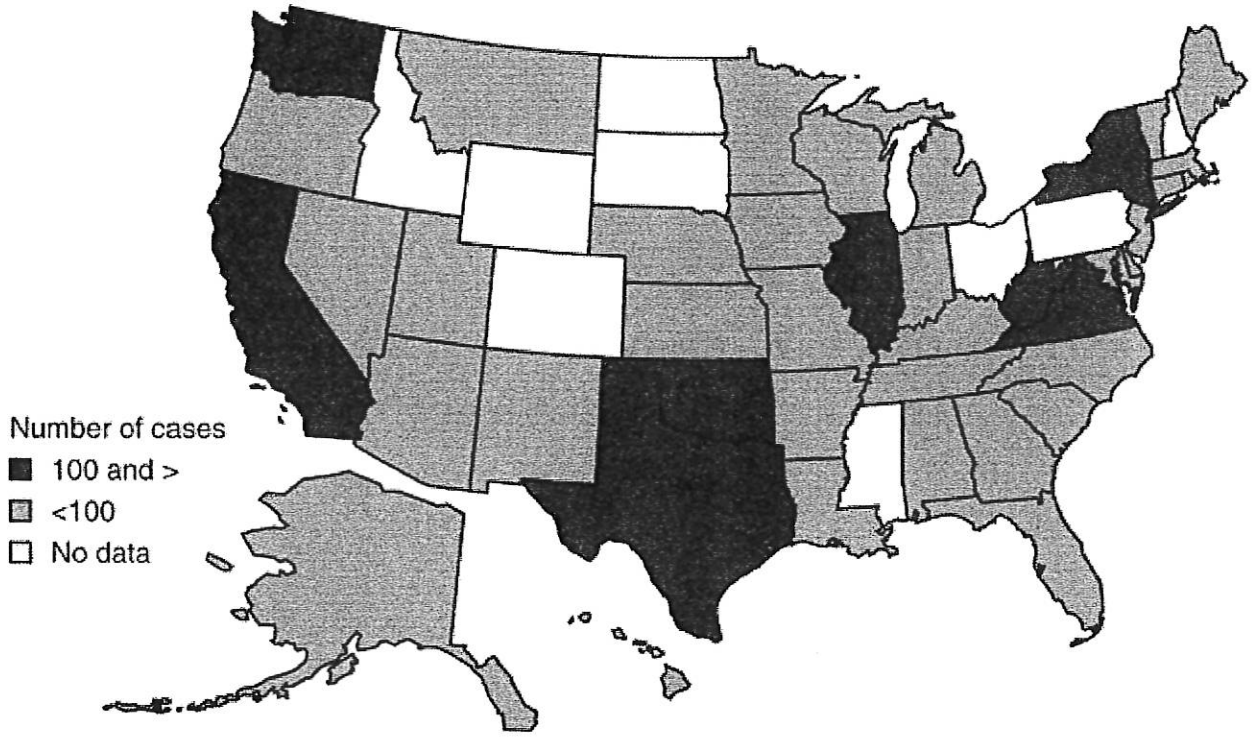


Figure 2–197. Number of cases of dust diseases of the lungs in private industry by State, 2001.
The number of dust diseases of the lungs within reporting States ranged from fewer than 50 cases to 200 in 2001. BLS reported 1,300 cases of dust diseases of the lung in 2001. Eight States (California, Illinois, New York, Oklahoma, Texas, Virginia, Washington, and West Virginia) reported 100 or more cases.
(Source: BLS [2002].)

Download data in Excel format Download image file in EPS format

√Silica or Silica Mixed Dust Exclusion

Policy No.	Eff. Date of Pol.	Exp. Date of Pol.	Eff. Date of End.	Producer	Add'l. Prem	Return Prem.
					$	$

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the:

Commercial General Liability Coverage Part
Products-Completed Operations Liability Coverage Part

The following additional exclusion is added to **2. Exclusions** of **Section I. Coverages:**

2. Exclusions

This insurance does not apply to:

Silica or Silica Mixed Dust

A. "Bodily injury", "property damage" or "personal and advertising injury" caused directly or indirectly, in whole or in part, by the actual, alleged or threatened inhalation, ingestion, absorption, exposure to, existence of or presence of "silica"; or

B Loss, costs or expenses arising out of the abating, testing for, monitoring, cleaning up, removing, containing, treating, detoxifying, neutralizing, remediating or disposing of, or in any manner responding to or assessing the effects of "silica" by any insured or by any other person or entity.

C For the purposes of this exclusion, the following definition applies:

"Silica" means:

(1) Any form of crystalline or non-crystalline (amorphous) silica, silica particles, silica compounds, silica dust or silica mixed or combined with dust or other particles; or

(2) Synthetic silica, including precipitated silica, silica gel, pyrogenic or fumed silica or silica-flour.

HAMM

QUARRIES
CONSTRUCTION
ASPHALT
WASTE MANAGEMENT

609 Peri , . iace
PO Box 17
Perry, KS 66073-0017
Telephone 785-597-5111
FAX 785-597-5117

TESTIMONY

By the

Hamm, Inc.

Before the
House Insurance Committee

Regarding SB 512
An Act Enacting the Silicosis Claims Act

March 14, 2006

Mr. Chairman and members of the committee my name is Ramon Gonzalez III, I'm an employee of Hamm, Inc, located in Perry, KS and a member of the Kansas Aggregate Producers' Association and the Kansas Contractors Association. I would like to take the time to thank you for allowing us to appear before you today in support of SB 512. N.R. Hamm Quarry, Inc. and N.R. Hamm Contractor, Inc., the two major subsidiaries of Hamm, Inc., have been providing crushed limestone products and heavy-highway construction for the state of Kansas for over 52 years. Hamm, Inc. is an employee owned company employing 270 to 300 Kansas citizens in over 16 counties in NE Kansas.

We thank you for the opportunity to come before you today to express our support for SB512, regarding silicosis claims.

We have a very diverse group of operations and we feel it is in our best interest to purchase insurance that covers all of our operations instead of one policy that covers each industry specifically. We believe this benefits Hamm Inc. because it provides economies of scale, it spreads risk, it limits the possibility of having gaps in our coverage and it increases the number of insurance companies that will cover certain parts of our operations.

Unfortunately, despite this strategy, we have seen the number of insurance companies willing to write coverage for our company shrink in the last five years. This is mainly because a shift in insurance companies' willingness to underwrite exposures in either heavy highway companies, paving contractors, quarry operations or companies with large auto fleets. One or more of these exposures usually makes the majority of insurance companies decline even a quotation, regardless of our very good loss record. Last year we have now seen companies formally giving us quotations now declining because of a *perceived* silica exposure. The insurance company's fear of silica exposures is not unique to the mining and construction industry as I'm sure you will hear today. If industry can not obtain multiple, competitive quotes from insurance companies then this will only drive up our cost which must be passed on to all public and private construction projects throughout the State. Companies in states with silica reform laws will have multiple competitive insurance quotes providing a distinct competitive advantage when bidding

public and private construction projects in Kansas. Hamm Inc. has brought fierce competition when bidding KDOT, KTA and county projects throughout the state for the last fifty years saving millions in taxpayer dollars.

N.R. Hamm Quarry, Inc. also provides crushed limestone products to Kansas counties and municipalities to use on rural roads and parking lots. The dust emitted just by driving on these roads by the general public could lead to frivolous class action lawsuits against the counties, townships and the producer of the crushed limestone. We feel actual claims should be made if medical evidence is present as this bill allows. Absent a bill requiring no evidence of silicosis we feel this could lead to massive unwarranted settlements, a reduction in the number of quarry operators in Kansas, or even threats of class action from residents who may only want their road to be paved by the municipality.

We believe that Senate Bill 512 will reduce the apprehension to the insurance companies declining to quote insurance to Kansas employers solely based on silica exposure. We also believe the state of Kansas, business and industry benefit from the elimination of the possibility of frivolous class actions claims from silica, similar to other frivolous class actions claims made in other states.

In closing, we appreciate the opportunity to appear before you. We urge this committee to recommend this bill favorably for passage. I would be willing to answer any questions you may have at the appropriate time. Thank you.

Legislative Testimony

SB 512

March 14, 2006

Testimony before the Kansas House Insurance Committee
By Lew Ebert, President and CEO

THE KANSAS CHAMBER

The Force for Business

835 SW Topeka Blvd.
Topeka, KS 66612-1671
785-357-6321
Fax: 785-357-4732
E-mail: info@kansaschamber.org
www.kansaschamber.org

Chairman Schultz and members of the committee;

The Kansas Chamber and it's over 10,000 members support SB 512, enacting medical criteria for silica claims. This bill will help compensate truly sick individuals without posing a threat to livelihood of an entire industry.

Silica litigation has followed the same path as asbestos litigation and while not as well known, could harm industries in the same manner. As silica-related diseases may be disappearing from American hospitals, lawsuits by alleged victims are on the rise. Companies have paid out an estimated $70 billion on approximately 730,000 asbestos injury claims, making it the most expensive type of litigation in U.S. history. Total corporate asbestos liability is now expected to exceed $200 billion. The problem is escalating as plaintiffs who have already received a recovery in asbestos claims are double-dipping and filing silica lawsuits. This is a real problem for many affected industries and many feel that silica claims are on the same litigation path as asbestos.

Because silica claims and diagnosis have mirrored asbestos litigation, Kansas, like other states, is seeing an insurance marketplace that is excluding companies with silica exposure. We need to address the concerns of these industries so that they can continue to compete in Kansas and employ Kansas workers. SB 512 will not cut off litigation for silica claims where the injured party truly is suffering an injury. With this bill in place, we believe that the insurance market may open up and again offer insurance to the affected industries.

We urge you to support SB 512. Thank you for your time and I will be happy to answer any questions.

The Kansas Chamber, with headquarters in Topeka, is the statewide business advocacy group moving Kansas towards becoming the best state in America to do business. The Kansas Chamber and its affiliate organization, The Kansas Chamber Federation, have more than 10,000 member businesses, including local and regional chambers of commerce and trade organizations. The Chamber represents small, medium and large employers all across Kansas.

Midway Sales & Distributing, Inc. d/b/a
MIDWAY WHOLESALE
Topeka • Salina • Lawrence • Manhattan • Elwood • Kansas City • Wichita

Presentation to the House Insurance Committee
March 14, 2006

By Kenneth L. Daniel
C.E.O., Midway Wholesale
Publisher, KsSmallBiz.com

Mister Chairman and Members of the Committee:

My name is Kenneth Daniel. I own a small business, publish a small business e-newsletter, and work as a volunteer advocate for small business.

Last month I testified to you about asbestos and silicosis, and my testimony today mirrors that.

I would like to testify in favor of Senate Bill 512 on behalf of myself and thousands of other Kansas small businesses. This bill will help to restore sanity and fairness for all parties involved in this legal travesty.

The asbestos litigation mess has already shown us that our legal system can be broken by attorneys who recruit clients who have no known damages, then attempt to extort money in the form of settlements without going to court.

Silica is the next asbestos. Thousands of people who have no symptoms of silica related health problems have filed lawsuits hoping to win the legal lottery. Many of those suits are simply bogus. Many more have been or will be filed on behalf of people without symptoms, allegedly to "reserve" a place in the legal system. The real reason is to reserve a place on the settlement list.

House Insurance
Date: 3-14-06
Attachment # 16

P.O. Box 1246 • 218 SE Branner Street • Topeka, KS 66601-1246 • (785) 232-4572 • Fax (785) 357-7794
www.midwaywholesale.com

This legislation will make those without symptoms wait until they actually have a problem.

Asbestos litigation has bankrupted many excellent U.S. companies, including several of our suppliers including Johns-Manville and Owens-Corning Fiberglas. The litigation has cost tens of thousands of high-paying jobs, and unless the current situation is fixed, it will cost many more.

Now, we will do the same damage with silica.

Down the road, as more and more silica suppliers declare bankruptcy, the legal scavengers will cast about for other victims as they have in asbestos. That means small manufacturers, distributors like me, even retail dealers and contractors.

My company fabricates some windows, doors, and gutter parts, but we <u>manufacture</u> nothing. Over the past 35 years we have handled very small quantities of materials that contain silica, but only in sealed packages or products where these minerals were encapsulated in asphalt or other materials.

Nonetheless, sooner or later, we expect the sharks to get around to us. We aren't afraid of having done something wrong, we are only afraid of being shaken down by trial lawyers using the courts to extort money from us.

Senate Bill 512 is your chance to help fix this problem in Kansas. I encourage you to support it.

AGC of KANSAS

Building a Better Kansas Since 1934

200 SW 33rd St. Topeka, KS 66611 785-266-4015

TESTIMONY OF
ASSOCIATED GENERAL CONTRACTORS OF KANSAS
BEFORE HOUSE COMMITTEE ON INSURANCE
SB 512

March 14, 2006

By Corey D Peterson, Associated General Contractors of Kansas, Inc.

Mister Chairman and members of the committee, my name is Corey D Peterson, Executive Vice President of the Associated General Contractors of Kansas, Inc. The AGC of Kansas is a trade association representing the commercial building construction industry, including general contractors, subcontractors and suppliers throughout Kansas (with the exception of Johnson and Wyandotte counties).

The AGC of Kansas supports Senate Bill 512 and requests that you report it favorably for passage.

As frivolous and suspect silicosis claims and lawsuits grow in number, construction companies are put at an unreasonable disadvantage as fewer insurance companies are willing to provide coverage. This in turn drives up the cost for our members who can find it.

The majority of AGC members are small businesses. This bill would protect small businesses from suspect claims, while maintaining the right of individuals who have actually been negatively affected. In addition to providing the proper protection for these individuals, limiting non-substantiated cases would most likely prompt insurance companies to remove policy exclusions for silica and mixed dust, which would result in a more affordable policy.

In closing, AGC of Kansas urges you to recommend Senate Bill 512 favorably for passage. Thank you.

THE KANSAS CONTRACTORS ASSOCIATION, INC.

316 SW 33RD ST • PO BOX 5061
TOPEKA KS 66605-0061
TEL (785) 266-4152
FAX (785) 266-6191
kca@ink.org
www.kansas.gov/kca

Testimony

By the Kansas Contractors Association

For the House and Insurance Committee

regarding

SB 512

March 14, 2006

Mr. Chairman and members of the House Insurance Committee, I am Bob Totten, Public Affairs Director for the Kansas Contractors Association. Our organization **represents over 350 companies** who are involved in the construction of highways and water treatment facilities in Kansas and the Midwest.

The Kansas Contractors Association supports SB 512 as we believe it will assist our companies in having adequate insurance coverage. Many of our members use or are exposed to silica every day and there is a concern some of our members may face the loss of liability insurance coverage as a result of silica exclusions. So far, our companies continue to have insurance coverage but either availability or the cost may be too extreme for some of our companies to continue to do business in the future if silica is restricted from their insurance coverage.

As you know, our companies are very instrumental in providing the continuation of the Kansas Comprehensive Transportation Program. We are concerned when anything that may hinder the ability to complete the program gets in the way of that opportunity.

We as an organization urge you to support SB 512.

House Insurance
Date: 3-14-06
Attachment # 18

Kansas Association of Insurance Agents

Testimony on Senate Bill 512
Before the House Insurance Committee
By Larry Magill
March 14, 2006

Thank you mister chairman and members of the committee for the opportunity to appear today in support of SB 512, the silicosis claims act. My name is Larry Magill and I represent the Kansas Association of Insurance Agents. We have approximately 425 member agencies across the state and another 125 branch offices that employ a total of approximately 2,500 people. Our members write roughly 70% of the business property and liability insurance in Kansas and 35% of the personal insurance. Independent agents are free to represent a number of different insurance companies.

For a number of years we have supported at the federal level asbestos reform that would require a claimant to have more than an exposure to a substance to make a claim, tying up the courts and tying up limited funds that could be going to seriously injured persons. In the case of asbestos litigation, we have seen the devastating effects of allowing claims to go forward when there is no medical evidence of injury. The U.S. House is now including silicosis in their proposed legislation.

Attached is an article based on recent National Public Radio coverage of silicosis mass tort claims emanating out of Mississippi that is the basis for this legislation.

The states of Florida, Texas, Georgia and Ohio have addressed this problem since Congress hasn't been able to. It is our understanding that this bill is based on Ohio's legislation. We support the concept that mere exposure is not a sufficient basis for making a claim and urge the committee to act favorably on this bill.

House Insurance
Date: 3-14-06
Attachment # 19

All Things Considered, March 6, 2006 · In a packed Texas courtroom last year, a federal judge accused doctors and lawyers of legal and medical fraud.

Silicosis is a deadly lung disease that industrial workers get from inhaling crystalline silica in foundries, mines, quarries and shipyards. Over the last few years, plaintiff lawyers aggressively advertised for silicosis victims, inviting them to mass medical screenings. As a result, state and federal courts were inundated with tens of thousands of silicosis claims.

But the lawsuits hit a major roadblock in Corpus Christi, Texas, when a judge warned a testifying doctor that he might want to get a lawyer before he said anything further. U.S. District Judge Janis Jack ruled that thousands of silicosis claims had been manufactured for money. Her ruling is having an impact on hundreds of thousands of asbestos and silica claims across the country.

A Sudden Avalanche of Litigation

Clean white sand -- the nemesis of golfers, the delight of young children -- goes into paint and glass and a thousand other products you'd both guess and wouldn't. But it can also kill you. Microscopic bits lodge in the most delicate and vulnerable places in your lungs and cause a terrible disease called silicosis. The disease is irreversible and progresses even when exposure stops. Beginning in the 1930s, silicosis cut a nasty gouge out of America's working class. In one notorious case, at least 764 workers died of the disease during the construction of Hawk's Nest Tunnel in West Virginia in the early '30s.

It took half a century, but government regulations eventually began to reduce the incidence of silicosis in the 1970s. So it was quite a surprise to John Ulizio, the CEO of U.S. Silica, when Fed Ex began pulling up to his company's building every day in the winter of 2002.

"The Fed Ex man started to show up with all of these lawsuits," Ulizio recalls. "In November of 2002, and running for a couple months after that date, we were inundated with over 20,000 new claims, by new people, almost all of which were in Mississippi, claiming that they had silicosis."

This was a disaster, maybe the end of U.S. Silica, the largest manufacturer of sand in the country. Were there going to be 20,000 more lawsuits in the next quarter? What in the world was happening in Mississippi?

"We kind of scratched our heads and figured, 'What the heck's going on down there?'" Ulizio says. "We kind of knew, almost as a matter of course, that they weren't real cases. Because, if you look at the federal CDC data on silicosis, there was no indication in the disease prevalence data that there was all of a sudden an epidemic of silicosis."

A Hidden Epidemic or Reaction to Tort Reform?

It was unprecedented. Suddenly, more silicosis cases were filed on single days in Mississippi than had previously been filed in an entire year. If true, it was evidence of one of the worst industrial disasters in American history. Yet no Mississippi public health officials were ever alerted, and no public health warnings ever issued. What was going on? The reason for this sudden legal activity was new tort reform laws that were being drawn up in the U.S. Senate and had already passed in Mississippi. Before the new laws kicked in, plaintiff lawyers rushed to file their cases. In the fertile ground of Mississippi's industrial Gulf Coast, lawyers began advertising for potential silica plaintiffs.

One television ad features a screen with the words "Silica Testing" in large type. Then a list of occupations begins to scroll: sandblasters, industrial painters, shipyard workers, brick masons, plumbers -- 19 different professions that qualified someone as a potential silicosis victim.

Delford Zarse, a plumber in the twilight of his career, says the ads were enough to make him pursue a silicosis claim. "I was talking to some guy who'd done this, and he said he'd collected quite a bit of money, and I see these ads in the paper, so I signed up," he says.

Before there were mass screenings for silicosis, there were mass screenings for asbestosis: That's how it all started. At first, the screenings targeted professions where workers were likely to have been exposed. But then, some plaintiff lawyers began going from town to town, advertising to and screening the general population. Turnout was good and thousands of new claims were generated this way -- including Zarse's claim. He says he's not sick, but he has been a plumber for 40 years. He went to an asbestos screening and was examined by a specially trained doctor hired by the lawyers. A few weeks later, Zarse got a letter: His X-ray had come back positive.

Zarse had 12 claims. Checks sometimes showed up in the mail, minus 40 percent for his lawyer. He got $11,000. Zarse smokes two packs of cigarettes a day and says he almost never gets sick. He has mixed emotions now about his lawsuit. On the one hand, he likes the money he got. "Anybody gives you money for nothing, you're crazy if you don't take it," Zarse says. But his conscience bothers him, too. "I think it's a rip-off of the companies," he says.

Screening Machine Shifts Course

The mass screenings are the heart of the controversy.

"Most of these people didn't go to their doctor first and get a diagnosis of silicosis, then go find a lawyer. They went to a screening and got a lawyer first," says Fred Kurtz. He's a Mississippi lawyer representing the defendants: sand producers, respirator and mask makers, and equipment manufacturers. In response to the flood of lawsuits, these companies went to their Republican allies in Congress for relief. Sen. Orrin Hatch (R-UT) began drafting new legislation that, if passed, would put plaintiff lawyers out of the asbestos business for good. And that unhappy prospect inspired some plaintiff firms to switch horses midstream. Instead of asbestos litigation, they'd concentrate more on silica lawsuits. Defense lawyer Danny Mulholland says in Mississippi, the well-oiled screening machine never missed a beat.

"It was the same plaintiffs' lawyers involved, the same doctors involved, the same screening companies -- in many instances, the same plaintiffs," says Mulholland. "What you saw was a shift in diagnosis from asbestosis to silicosis. "

All of a sudden, silicosis claims in Mississippi began going through the roof. And the heart of these lawsuits is the diagnoses of the doctors hired by the lawyers. It is these so-called litigation doctors who are at the center of the controversy.

The 'Litigation Doctors'

Dr. Jay Segarra is a pulmonologist, which means he specializes in lung disease. He says he spent the first 15 years of his medical career serving his country in the Air Force. He fell into X-ray reading in Biloxi, Miss., in 1991 after his discharge. The work started slowly but then really picked up steam in the mid-'90s. Doctors like Segarra are X-ray reading specialists called "B-readers." There are just a few hundred across the country, but the most prolific are responsible for a stunning number of lawsuits. For example, Segarra has diagnosed 29,000 claims of asbestosis. Defense lawyers say he's made thousands of silicosis diagnoses, too.

"Yes, I may have diagnosed that many cases -- and I don't know if I have or not," Segarra says. "But they don't know how many that I've looked at and haven't found any disease."

Reading lung X-rays for evidence of asbestosis or silicosis is not a perfect science. In some cases, an X-ray one doctor might read as positive, a different doctor might read as negative. Segarra says that in spite of his prodigious numbers, his diagnoses have always been done in good faith.

"I'm certainly not a schemer at all," Segarra says. "But am I opportunistic? I suppose I am. But everybody is."

Segarra estimates he has made about $10 million doing this work. When called to testify, he parries cross-examinations with skill. But the Mississippi lawsuits have brought an unusually intense scrutiny. That's because the silicosis defendants decided to fight. The cases were assigned to a federal judge who ordered that the medical and exposure history on *every one* of the 10,000 silicosis claims be turned over to the defense lawyers. That was unprecedented: Usually the court investigates only a sample of the claims. Armed with that information, the defense lawyers also did something surprising. Defense lawyer Mullholland says they ran the silicosis plaintiffs' social security numbers through the nation's largest asbestos databank.

Retread Patients

"If you only knew about John Doe who was diagnosed on February 15th you might know everything there is to know about John Doe," Mulholland says. "But the complexion of that information changes when you know there were 110 people who walked through the same door, on the same day, to the same doctor that John Doe did."

It was a eureka moment. It turned out that 68 percent of the 10,000 claimants had previously filed asbestos claims. Pulmonary experts say the number of people known to have developed both silicosis and asbestosis is infinitesimally small. But here were thousands of victims with both diseases. When Segarra is presented with evidence that he has diagnosed the same person with asbestosis one time and then silicosis the next, he says he's not surprised.

"I have looked at thousands of X-rays and made thousands of diagnosis," Segarra says. "If I did not have at least one person like this, then there's something wrong.

"The nature of the science itself is imprecise. You cannot get around that."

Defense lawyers call these cases "retreads" -- people with previous asbestos claims who are later reinvented as silicosis victims, or vice versa. We showed Segarra one of his retreads -- two reports, nine months apart, on the same man. The first time, Segarra diagnosed the man as having silicosis. The second time he said the man had asbestosis. And in his second report, he wrote that he found *no evidence* of silicosis. Segarra didn't realize he was diagnosing the same man twice. Plaintiff lawyers send him thousands of X-rays a year. But what did this plaintiff have --silicosis, asbestosis, both or neither?

"It's impossible for me to say, all the factors that went into these two diagnoses being different," Segarra says. "You can certainly pick out single cases which don't look good, like this one: I've made a total different X-ray diagnosis from one point to the other. But what you will not find is a systematic switch over a large number of cases. You will not find that in my files."

Defense lawyers say they have evidence that Segarra made scores of mistakes like this. Other B-readers made these mistakes, too: One doctor has thousands of these so-called retreads. For 15 years, these mass screenings have provided plaintiff lawyers, defense lawyers, doctors and screening company executives a handsome living. But it all started to come to apart when a federal judge in Corpus Christi was randomly assigned thousands of the silicosis claims from Mississippi.

A Judge with a Nurse's Instincts

U.S. District Judge Janis Jack is a bridge-playing, whiskey-drinking Clinton appointee in Texas. But it wasn't Jack's politics that defined her approach to these silicosis cases: it was her medical background. Before she became a judge, Jack had been a nurse. The more she learned about the screening process, the more her alarm bells went off. So she ordered that depositions take place in her courtroom, and she did a lot of the questioning herself. NPR has exclusively acquired the courtroom audio. In one exchange between the judge and Heath Mason, CEO of N&M, one of Mississippi's big screening companies, Jack asked him where all the people being screened were coming from. "From what I know, a lot of, some of their initial silica people were their existing asbestos people," Mason told her, saying the patients were re-screened for silicosis.

"We were set to do mass screenings," Mason said in court. "I mean, that's what we did. And from a business standpoint of mine, we had to do large numbers. "

Mason's screening company's rates for testing people positive for silicosis approached 90 percent. His staff, not doctors, took perfunctory work and medical histories. And with some of his biggest clients, it behooved Mason to have a high rate of positive X-rays, because those lawyers only paid him for positive results -- $750 for each. Through his lawyer, Mason declined to comment for this story.

From Expert Witness to Possible Defendant

But it was the doctors' depositions that produced the most fireworks. The country's most prolific B-reader is a doctor named Ray Harron from West Virginia. Harron is responsible for at least 88,000 legal claims. His reputation began to crumble in Jack's court when defense lawyers started producing evidence of double diagnoses. In one courtroom exchange, excerpted below, a defense lawyer asked Harron how it was possible that his asbestos diagnosis of a man named Kimball seemed to disappear eight years later, when Harron diagnosed Kimball with silicosis.

LAWYER: "And those scars over time, are going to get worse, right?"

HARRON: "Right."

LAWYER: "And as a matter of fact, you said that somebody with those fibers and scars in their lungs are gonna go to their grave with them, right?"

HARRON: "Right."

LAWYER: "Not Mr. Kimball."

The defense then displayed a later set of X-rays. In these films, Kimball now has silicosis, but his asbestosis has cleared up. Judge Jack pressed Harron to explain. She asked, "So now his asbestosis is gone?"

HARRON: "Well, I can't say that it's gone, your honor."

JUDGE JACK: "Well, where'd it go?"

HARRON: "Like I say, I don't know."

Harron offered an explanation: Perhaps the film contrasts were different. But defense lawyers have plenty of examples of Harron's double diagnoses. As they produced the evidence, the doctor's situation on the stand became precarious. He took the stand as an expert witness, but it became clear that his answers could result in his prosecution for fraud. At one point, the judge stopped defense lawyer Mulholland from questioning Harron, suggesting that the doctor should stop talking and obtain legal representation.

Under questioning, the reputations of other B-reader doctors were damaged also. One withdrew hundreds of his silicosis diagnoses, saying he never meant for them to be considered actual diagnoses. By the time the depositions were over, Judge Jack was appalled to find that 6,800 of

the 10,000 silicosis claims also had asbestos claims. But Jack found that the chances of any one person having both diseases were about the same as a golfer making a hole in one. She said that Harron's testimony raised "great red flags of fraud." The judge wrote a 249-page ruling throwing out the testimony of doctors, sanctioning the lawyers and discrediting the mass screenings. Her conclusion? The 10,000 silicosis claims were "manufactured for money."

A Ruling with Far-Reaching Implications

Brent Coon disagrees with much of Jack's ruling. He's a plaintiff's lawyer for some of the silicosis cases in her court. "Judge Jack, she's a fine judge," Coon says. "But I don't think she's very sophisticated about the process. I think this was the first time she'd actually had these complex mass tort cases in her courtroom."

Coon concedes there were problems with some of the diagnoses in the silicosis cases and says Jack properly weeded those out. But Coon says screenings help save workers' lives by alerting them to possible lung illness earlier than they might otherwise have known.

"She discredited some of the doctors involved, but I don't think it's an indictment of the entire process," Coon says. "The process is very good, the concept is very good. Whether or not it's abused from time to time is something that can be controlled and should be controlled."

Coon says it would be an injustice to use the Mississippi cases to try to strip away workers' legal options. Judge Jack's ruling has become a rallying cry for corporate America, the editorial board of *The Wall Street Journal* and the U.S. Chamber of Commerce. Coon says big business wants to use the judge's opinion to create a permanent legal handicap for poisoned workers.

"Those companies knew for decades that those products crippled people and killed people. They knew it," Coon says. "We've got all the documents, all the internal memo, all the depositions that prove that. And it's a shame that now they're able to isolate a few example cases and try to turn that around."

Without question, there are hundreds of industrial workers across the country acutely ill with silicosis. Even the defendants concede that is true. But instead of standing out, their lawsuits float along, jumbled together with thousands of claims generated from mass screenings, clogging court dockets and delaying their opportunity for relief. Time is not on their side.

Judge Jack's methods of deposition and her ruling are beginning to have an impact around the country. In Florida, a judge has ordered silicosis plaintiff lawyers to produce detailed medical information on their claims. In Ohio, a state court handling 35,000 asbestos claims and 900 silica claims is considering calling hearings to depose the doctors the same way Jack did. And on Capital Hill, the House Subcommittee on Commerce and Energy begins its investigation into the Mississippi lawsuits. Like a little legal pebble, the opinion of the nurse who became a federal judge is sending out ripples of change across the nation's court system.

Anne Hawke produced this report.

KANSAS TRIAL LAWYERS ASSOCIATION

Lawyers Representing Consumers

To: Rep. Clark Shultz, Chair
House Committee on Insurance

From: William J. Skepnek
On behalf of the Kansas Trial Lawyers Association

Date: March 14, 2006

Re: SB 512 Silicosis Claims Act

I appear before you today on behalf of the Kansas Trial Lawyers Association, a statewide nonprofit organization of attorneys who represent consumers and advocate for the safety of families and the preservation of Kansas' civil justice system. I appreciate the opportunity to provide you with testimony on SB 512. KTLA is opposed to SB 512 and asks that it not be passed.

I come before this committee with a broad basis of experience in this particular area of law. I am a 1978 graduate of the University of Kansas Law School, and am admitted to practice before various United States District Courts, Courts of Appeal, and the United States Supreme Court. I am also admitted to practice in Kansas, Oklahoma, and Texas. I am currently involved in representing people in cases pending in Houston, TX, who were victims of an aggregate settlement involving hundreds of silicosis claims. I have also served as the primary defense counsel for a manufacturer of asbestos, in asbestos litigation covering a seven state region, including Oklahoma, Arkansas, Louisiana, Texas, New Mexico, Colorado, and Utah. In doing so I pursued claims against asbestos plaintiffs' lawyers who submitted sham claims for payment. (See, *How About a Tony for Best Asbestos-Related Script?*, Wall Street Journal, 10/7/97). I am also known nationally for pursuing litigation which has resulted in expanding the liability of mass tort lawyers to their clients for breaching their fiduciary duties in connection with aggregate settlements. (See, e.g., *Plaintiffs Win Right to Sue Lawyers,* New York Times, 9/11/97.) During the past several years I have consulted with "tort reform" groups on issues relating to the asbestos litigation. I am also a lecturer at the University of Kansas in the Honors Western Civilization Program, where I was appointed the Director of Study Abroad for the Fall of 2005.

A good starting point of my testimony is to note there is no body of silica litigation in Kansas. The KTLA, in attempting to research the matter found the last silicosis verdict in Kansas in 1968. During the past 38 years not a single case is recorded in Kansas. No Kansas law firms have practices which are devoted to the filing of silica in Kansas Courts. Why, then would the insurance industry be earnest about solving a problem which does not exist? Why does KTLA bother contesting this bill, and why would I take the time to appear to give testimony in opposition?

The proposed legislation violates basic principles upon which our law is built. The Kansas Code of

House Insurance
Date: 3-14-06
Attachment # 20

Terry Humphrey, Executive Director

Fire Station No. 2 • 719 SW Van Buren Street, Suite 100 • Topeka, Ks 66603-3715 • 785.232.7756 • Fax 785.232.7730

E-Mail: triallaw @ ink.org

Civil Procedure has not been extensively *Jerrymandered*. Historically, Kansas has created simple rules of broad application, which are not designed to favor any special interests. The belief has been that uniform rules, applied by qualified judges, and committed the discretion of free, and educated juries, is the best guarantee of justice. This Bill violates that principle.

The law operates by precedent. Once a court makes a ruling concerning a particular set of facts, the system is designed to repeat the result. Legislatures tend to act in the same way. Lawmakers want to be consistent. In this case, the insurance industry is attempting to blackmail Kansans into creating special rules for particular kinds of claims. They ask this legislature to create special protections for claims of a particular type; claims, which all agree are not, and have never been a problem in Kansas. They want special rules that apply solely to "silicosis" claims. Once this is accomplished, and the precedent has been established, we'll be told we need special rules for automobile claims, for aircraft litigation, or medical malpractice, the list is endless. Our simple code of civil procedure will become a Byzantine morass, because we took the easy route, and gave in to a demand for special treatment by a special interest.

In fact, the present national mass tort "crisis" is a problem which can be laid at the feet of a number of interests. The "mass tort" plaintiffs' bar bears a large share of the blame, but so do the insurance industry, and the defense bar, and judges. It is merely a problem of enforcing effective rules that are already in place. There already exist adequate procedural protections against the pursuit of meritless claims. Lawyers who file them can and should be punished, or subjected to civil liability under already existing law. Defense firms who have profited from this "industry" have been loath to kill the "Golden Goose." Corporations, and the insurance companies which provide them with coverage have been quick to seek mass answers to the problems presented by individual cases. They have encouraged plaintiffs' lawyers to "gather up" large numbers of claimants and settle their claims in mass settlements, without the need of individual evaluation of claims.

In short, the problem does not require the enactment of new and complicating laws. What is needed is enforcement of existing rules. My law school classmate, John Klamann, on February 21, 2006, submitted a thoughtful and extensive analysis of the proposed legislation relating to silica and asbestos, which applies with equal force to this bill. I adopt that analysis for incorporation into my testimony, and ask the committee to consider it at this time.

The need for SB 512 is predicated on an assumption that there is a tort crisis in Kansas. However, review of Kansas court cases shows that the so-called "litigation crisis" is a myth. In fact, only 2% of cases filed in Kansas are torts, and of that 2%, only 115 were decided by a jury. The median award in 2004 was $18,757, down from $23,416 in 2003. KTLA strongly discourages the Committee from shaping public policy based on the fiction that there is a crisis in Kansas.

In addition, Kansas does not need additional "tort reform" measures because Kansas already has in place strict laws that rigorously control tort cases. Kansas' comparative negligence law (K.S.A. 60-258a) requires that juries divide damages between the plaintiff and negligent defendants according to relative fault. For example, if the jury determines that a defendant is 70% at fault and a plaintiff is 30% at fault, the defendant would be accountable only for 70% of the damages. Kansas also has a cap on non-economic damages that limits recovery of so-called pain and suffering to $250,000

(K.S.A. 60-19a02). Given these laws, and the lack of a tort crisis, we strongly question the need for SB 512.

SB 512 is a fix looking for a problem. The bill offers no public purpose. For good reason: to our knowledge, there is very little – if any – silicosis litigation in Kansas, much less something of the magnitude that would trigger such a wide-sweeping, constitutionally-infirm immunity bill. It impugns the concept of justice because it eliminates a remedy and offers no *quid pro quo*. In short, its proponents do not define the bill's concerns, the bill itself raises more questions than it answers, and it actually creates litigation problems.

If the intent of SB 512 is to immunize employers and owners, then it duplicates the workers' compensation scheme that we already have. If the bill is intended to immunize third parties, it does so without indicating why or who. We cannot even decipher a pattern as to "why or who" from a review of Kansas cases, because there are none.

By its very terms, SB 512 doesn't solve a litigation problem; it creates one by virtually flipping century-old legal processes upside down. SB 512 makes it virtually impossible for any plaintiff to meet the requirements in this bill to show that they have a legitimate case. For example, among other things, it requires every plaintiff to establish the nature, extent, and duration of exposure to silica and/or mixed dust. Sec. 2(b)(2)(A). This requirement helps to establish specific causation, a viable part of every personal injury lawsuit. *Yet, the bill demands that plaintiffs produce this information within 60 days after filing the case.* Sec. 4(a). But the nature, extent, and duration of exposure depend entirely on defendant-held information, specifically, whether or not defendant actually sampled for silica/mixed dust, submitted the samples to a forensics lab, received the results, and then acted on them as required according to NIOSH – not OSHA – standards, and certainly not the undefined 1972 standards supposedly adopted in Kansas. And defendants do not provide that information to any adversary willingly, especially within 60 days after filing a case. In fact, in my experience they produce that information only through discovery during litigation that occurs long-after 60 days from filing the case, and sometimes only if threatened with sanctions for failure to produce. Moreover, even if a defendant willingly provided the information within the 60 days, an expert must review the data and determine the overall exposure level, a time-consuming assimilation process.

As another example, the bill requires that the plaintiff produce evidence from a "competent medical authority" that he is physically impaired due to a medical condition for which silica is a substantial contributing factor. Sec. 2(b). This requirement also helps to establish specific causation. Yet, the bill problematically requires that the "competent medical authority" must be the plaintiff's treating doctor currently or sometime in the past, who spends no more than 25% of his practice time on testimony, gains no more than 20% of his revenue from testifying, and <u>does not rely on the report or opinion of any doctor, clinic, lab, or testing company</u> that has examined or screened the plaintiff. Sec. 1(i). But, because it can be mistaken for other diseases, silicosis more often than not requires an expert to diagnose it, experts who review the treating physician's work, the plaintiff's radiological/pathological test results, and sometimes the plaintiff himself. We find these consulting experts not in the local hospitals and clinics, but in the major research and teaching facilities in this country: Sloan Kettering, M.D. Anderson, Mayo Clinic, Johns-Hopkins, just to name a few. It is

difficult to get an appointment with an expert physician quickly, as they are in high demand. And they are very expensive doctors, making them inaccessible to many people as experts, much less as treating physicians. Moreover, they invariably seek to review only original X-rays/scans, seldom available without subpoena power through litigation and never in short order. So, again, the bill makes it virtually impossible for any plaintiff to meet the requirements to show a legitimate case, especially within 60 days from filing the case.

Further, SB 512 would require that every "competent medical authority" either provide an affidavit regarding the 25% testimony/20% revenue issue or provide a plaintiff financial records to satisfy the bill's requirements. This provision appears to target charlatanism, a problem that nobody likes. Yet, it burdens doctors and plaintiffs unnecessarily and may jeopardize doctors' financial privacy.

SB 512 punishes a plaintiff that fails to meet the bill's burdensome evidence requirements and time limitations to prove her case. When a plaintiff cannot get her hands on the exposure data or could not afford a treating physician with the experience to diagnose silicosis, the court must dismiss her case . . . treating it as a summary judgment. Sec. 4(b). It is any unbroken rule that a summary judgment is a ruling on the legal merits of the case and not on the factual questions, such as those that surround evidence. It prevents issues from reaching the jury because there is nothing in those issues for the jury to consider. Factual questions go to the jury. Yet, this bill forces the court to consider the factual questions and treat them as legal ones, keeping them from a jury, a situation that the legal process does not tolerate. In effect, it creates a litigation problem.

SB 512 indicates the exposure standards as adopted in Kansas in 1972 apply here, but does not specify under what statute they may be found or suggest to what substance they apply. The bill blatantly does not recognize that silica/mixed dust (that includes silica as an ingredient) exposure standards have changed greatly over the past 40 years. For example, silica was thought to be a human carcinogen up until about 1991 and, thanks to research from Dr. David Goldsmith *et al.*, was thereafter so classified. At that point exposure levels and respiratory protection requirements became more stringent. OSHA standards do not apply in all environments and are less stringent than those of NIOSH (National Institute Of Occupational Safety and Health, part of the Centers for Disease Control), the "gold standard" of standards.

SB 512 also denies the plaintiff's due process rights to have the jury even know about any findings that the court made on the evidentiary issues that may go against the defendant – all of those findings being part of the trial record and traditionally available as evidence. Sec. 2(f).

In short, SB 512 eliminates a remedy with no *quid pro quo*, has no problem to fix, raises more questions than it answers, and creates litigation problems. On behalf of the Kansas Trial Lawyers Association, I ask you to oppose SB 512.

KANSAS TRIAL LAWYERS ASSOCIATION

Lawyers Representing Consumers

To: Representative Clark Shultz, Chair
Members of the House Insurance Committee

From: Callie Jill Denton, Director of Public Affairs

Date: March 14, 2006

RE: SB 512 Silicosis

I am submitting testimony on behalf of the Kansas Trial Lawyers Association, a statewide nonprofit organization of attorneys who represent consumers and advocate for the safety of families and the preservation of Kansas' civil justice system. I appreciate the opportunity to provide the Committee with comments on SB 512.

I was before this Committee a few weeks back during the consideration of HB 2868 (silicosis and asbestosis claims). At that time John Klamann went into great detail about the pitfalls, unintended consequences, and ill-advised policies within HB 2868. SB 512 is very similar to HB 2868 and therefore we oppose it on similar grounds.

In addition, we renew our request for the Legislature to further study the issue of silicosis before passing any legislation. Specifically:

1. *Send SB 512 to the Kansas Judicial Council for review.* The Kansas Judicial Council was created in 1927 and it is responsible for continuously studying the judicial branch and recommending options, including legislation, that improve the administration of justice in Kansas. It includes a Civil Code Advisory Committee that is charged with reviewing the civil code and related areas of law. The Kansas Judicial Council has previously reviewed major policy changes to the code of civil procedure, and it should weigh in on SB 512. Specifically, it should review the status of silicosis litigation in this state, whether the changes in SB 512 are need, and the potential impacts of SB 512 on silicosis claims.

2. *Send SB 512 to an interim committee for further study by the Legislature.* As discussed, there is no silicosis crisis in Kansas that requires immediate action. The changes in SB 512 are significant and warrant appropriate and considerate review before they are enacted by the Legislature.

House Insurance
Date: 3-14-06
Attachment # 21

Terry Humphrey, Executive Director

Fire Station No. 2 • 719 SW Van Buren Street, Suite 100 • Topeka, Ks 66603-3715 • 785.232.7756 • Fax 785.232.7730

E-Mail: triallaw @ ink.org

KTLA remains available to work with any and all parties to craft a compromise while the Legislature continues its review of the issues raised by SB 512, and we have extended an offer to the proponents to discuss their concerns in more detail.

Silicosis and silicosis litigation is not an issue in Kansas: the amount of silica in Kansas rock is so low that in some cases it is not measurable and the risk of exposure to silica is therefore low; there is little, if any, silicosis litigation in Kansas; and less than 1.1% of mortality in Kansas is from silicosis. We are not aware of any silicosis cases in Kansas since 1968.

The objective of SB 512 appears to be, first and foremost, to shield silica manufacturers from accountability for the products they've placed in the hands of consumers and in the workplace. The bill imposes new standards for silica claims that differ from other areas of Kansas' civil procedure laws. SB 512 disadvantages injured persons who have legitimate claims against silica manufacturers, which KTLA believes is unfair and not warranted.

KTLA condemns the mass tort screenings and fraudulent activity that was the subject of a recent U.S. Congressional subcommittee hearing. We believe that those that are found guilty of fraud should be prosecuted to the fullest extent of the law (including the physicians who made the "diagnoses" and invoked their Fifth Amendment rights rather than testify to the House subcommittee). However, the civil justice system is properly dealing with everyone associated with these unfortunate cases because the cases were thrown out of court and federal investigators are looking into whether those involved should be prosecuted.

KTLA believes that Kansas courts are able to effectively handle silica cases and that there are protections in place for dealing with fraudulent or frivolous filings. More study is needed to determine if there is any need for silica legislation in Kansas, and if so, how it must be crafted so that legitimate claims are not impaired or barred altogether and corporate wrongdoing is not hidden or protected.

On behalf of the Kansas Trial Lawyers Association, I urge your opposition to SB 512.

MEMORANDUM

To: Senator Ruth Teichman, Chair
Members of the Senate Financial Institutions and Insurance Committee

From: Terry Humphrey, Executive Director
Callie Jill Denton, Director of Public Affairs

Date: February 21, 2006

RE: SB 512 Silicosis Claims Act: Response to Proponents' Balloon Amendments

KTLA is responding to the balloon amendment submitted by proponents of SB 512 on February 21, 2006. Unfortunately, the amendments don't even touch the surface of the problems with SB 512. Concern remains with the following:

Section 1 Definitions.

- In the definition of "AMA guides to the evaluation of permanent impairment", the delegation of authority to the American Medical Association is not constitutional under Kansas law.
- The definition of "competent medical authority" requires a physician that is a board-certified internist, board-certified oncologist, board-certified occupational medicine specialist, board-certified pathologist, or board-certified pulmonary specialist. We question whether Kansans in the more rural parts of the state have access to these types of health care providers. Because "competent medical authority" also requires that the physician be treating the injured person or have a doctor-patient relationship, Kansans could be forced to go outside their home towns or outside the state to be seen by a doctor that meets the requirements of the bill. However, Kansans would be precluded from using a true asbestos expert since such an expert may not meet the requirement that they not spend more than 25% of their practice on consulting. The requirement that "competent medical authorities" also not earn more than 20% from consulting would require lengthy and inappropriate review of the physician's financial records. This standard is

also unnecessary because Kansas already has standards for qualification of expert witnesses.

- The new definition of "employee" in the proponents' balloon appears to have erroneously excluded listing of the 10 criteria referred to in the definition.
- The proponents have not shown that the definitions of "pathological evidence of mixed dust pneumoconiosis", "pathological evidence of silicosis", "radiological evidence of mixed dust pneumoconiosis" and radiological evidence of silicosis" reflect generally accepted standards; we are concerned that they do not.
- The definition of "physical impairment" distinguishes between smokers and non-smokers. The bill later defines a "smoker" by a very low threshold, punishing those that smoked for a short period of time, have quit, or perhaps have been exposed to passive smoke. Further, the proponents have not demonstrated why the distinction between smokers and nonsmokers is important for purposes of developing silicosis or mixed dust disease.
- The definition of "smoker" appears to contain an error. We do not know what "the equivalent one pack year" is. It appears that anyone who has smoked the equivalent of one pack of cigarettes anytime in the preceding fifteen years would be considered a "smoker". We believe this definition is unfairly broad, especially since the bill treats "smokers" and nonsmokers differently. A separate consequence is that the bill could affect those exposed to passive smoke if such exposure is equivalent to "one pack year".
- The definition of "substantial contributing factor" is problematic because it is in conflict with Kansas' comparative negligence system. Kansas' comparative negligence law (K.S.A. 60-258a) requires that juries divide damages between the plaintiff and negligent defendants according to relative fault. For example, if the jury determines that a defendant is 70% at fault and a plaintiff is 30% at fault, the defendant would be accountable only for 70% of the damages. The "substantial contributing factor" requirements moves away from our current system of apportioning accountability. In addition, the definition of "substantial contributing factor" includes requirements for a "competent medical authority". As noted, we are concerned that injured persons will be unable to find a "competent medical authority" as required by the definition of the bill, and therefore would also have trouble establishing that silica or mixed dust disease was a "substantial contributing factor" in their physical impairment. "Substantial contributing factor" also relies on the term "physical impairment". As previously noted, the definition of "physical impairment" places unreasonable standards of the injured person, particularly relating to whether or not they might be considered a smoker.
- The definitions of "substantial occupational exposure to silica" and "substantial occupational exposure to mixed dust" both require a cumulative five-year exposure period. However, since acute silicosis can result from exposure of less than five years to large amounts of silica, the bill appears to preclude recovery for any acute silicosis injuries.

Section 2.

- Subsections (a), (b), (c), and (d) rely on defective and questionable definitions of "physical impairment", "substantial contributing factor" "competent medical authority" "radiological or pathological evidence", "smoker", and "substantial occupational exposure to silica".
- The bill requires a "competent medical authority" to provide a detailed occupational and exposure history that requires inclusion of information that is in the defendant's control and normally would not be available to the injured party absent a discovery process. This information includes the general nature, duration, and general levels of exposure and all of the airborne contaminants the injured person was exposed to. Since "competent medical authority" and the exposed person likely do not have this information, the exposed person will be unable to make the bill's required "prima facie showing".
- The bill requires a "competent medical authority" to provide a detailed medical and smoking history of the exposed person's past and present medical problems, as well as the most probably causes of the medical problems. This information is excessive and unnecessary for what should be a minimal, "prima facie showing".
- The bill requires that a "competent medical authority" perform pulmonary function testing. We question whether this type of testing is available in medically underserved areas.
- The bill prohibits "smokers" as defined by the bill from making a prima facie showing unless it has been at least 10 years since their first exposure to silica. "Smoker" is so broadly defined as to include people who have quit smoking, have smoked very little, or who have been subjected to passive smoking. The 10 year requirement is inconsistent with silicosis diseases, since acute silicosis can develop in less than five years, and accelerated silicosis can develop in as little as 5 years.
- The bill requires that injured persons defined as "smokers" under the bill who develop lung cancer and those that allege wrongful death as a result of exposure to silica demonstrate that they have had "substantial occupational exposure" to silica. Again, the definition of "substantial occupational exposure" is arbitrary and appears to defy medical science. Further, we are not clear on why "smokers" that develop lung cancer and the families of the deceased are required to demonstrate "substantial occupational exposure" while an individual with nonmalignant silicosis is not. The effect of the distinction appears to be to discourage claims by requiring greater standards for those with malignancies or wrongful death cases.
- Despite requiring injured parties to substantially prepare and present their cases at the time their cases is filed, the bill prohibits the information in the prima-facie showing from being admissible at trial, and the jury is not permitted to be informed of the prima-facie showing. We question whether the injured party would be required to develop an entirely new analysis, witnesses, and demonstration of the critical parts of their case as a result of these prohibitions, which would be an unfair burden.

Section 3. Our concerns are similar to those expressed with regard to Section 2.

Section 4.

- The proponents have extended the injured person's deadline for filing the "prima facie showing" from 30 days after filing the complaint or initial pleading to 60 days. Given the burdens created for the injured person in SB 512, 60 days is still woefully inadequate to develop the required information.
- The bill permits the court to "administratively dismiss" the plaintiff's claim for failure to make a prima facie showing. In Kansas Civil Procedure, there is no process for "administratively dismissing".

Section 5.

The bill appears to establish separate statutes of limitations for mixed dust disease and silica claims and cuts off the recovery of potential future injuries, which is permitted under current law.

Section 6.

- The bill gives complete immunity to "premises owners" unless the individual's exposure occurred on the premises owner's property. As a result, the bill cuts off claims from landowners adjoining the premises owner's property who may suffer the effects of silica and mixed dust air pollution caused by the premises owner. Such "neighbors" would have no cause of action against the "premises owner" under SB 512.
- The bill, in (c) (3), refers to "plaintiff's breathing zone". Proponents have not provided any standards for this term, or its definition.
- The bill limits the liability of a premises owner for injury caused by contractor's employees or agents except when the premises owner's acts are intentional. This standard is too high and shields the premises owner from accountability.
- Deletions at (d) appear to be without substantive effect since these definitions were moved elsewhere in the bill.

Section 9.

We support the deletion of the provisions in this section.

We believe the above problems and others were identified in the analysis by conferee John Klamann at the February 13 hearings (attached). Again, the February 21 balloon amendments from proponents do not fully, or even partially, address the major concerns raised by the bill, and therefore we continue to ask that SB 512 not be permitted to advance.

MEMORANDUM

To: Senator Ruth Teichman, Chair
Members of the Senate Financial Institutions and Insurance Committee

From: Terry Humphrey, Executive Director
Callie Jill Denton, Director of Public Affairs

Date: February 15, 2006

RE: SB 512 Silicosis Claims Act: Request for Interim Study

The Kansas Trial Lawyers Association has grave concerns with SB 512. Proponents of SB 512 are seeking sweeping changes to Kansas law despite their own testimony indicating that silicosis and silicosis litigation is not an issue in Kansas: the amount of silica in Kansas rock is so low that in some cases it is not measurable and the risk of exposure to silica is therefore low; there is little, if any, silicosis litigation in Kansas; and less than 1.1% of mortality in Kansas is from silicosis.

According to proponents, SB 512 is needed because insurers are refusing to offer coverage for silicosis claims to Kansas businesses. Yet, SB 512 does not address the actions of the insurers that, despite the low risk of silicosis in this state, are refusing to offer such coverage. Instead, SB 512 makes unsound, unscientific, overwhelmingly biased policy that is heavily weighted against those who might in the future suffer from what is a debilitating and highly preventable disease.

The proponents have testified that the "peanut" of the bills is that "any potential third party wishing to lodge a silica claim against foreign exposure against a producer would have the duty of providing a bona fide medically diagnosed illness prior to filing their claim." (KAPA testimony, 2/13/06). We note that the current law already requires any plaintiff to state their claim in a manner that relief can be granted, which includes articulating the nature of their injury or harm caused. SB 512 goes beyond the "peanut", which is current law anyway, and unfairly imposes harsh new requirements on those that have been injured by silicosis.

In addition to the above, SB 512 contains other defects that require additional committee attention. Specifically:

1. The bill so limits the "competent medical authority" that may diagnose silicosis that a patient would most likely not be able to obtain a physician qualified to diagnose their condition and meet the requirements of the bill.

2. The bill imposes unreasonable limits on patients by requiring them to obtain all evidence of their case within 30 days of its filing when critical information about the case is held by the defendant and likely would not be turned over without a lengthy discovery process. The new requirement of SB 512 virtually flips century-old legal processes their head.

3. The bill requires criteria that are unsound. For example, the bill does not recognize that exposure standards have changed and exposure levels and respiratory protection requirements have become more stringent.

4. The bill has constitutionality problems. There is no justification for why the bill provides blank immunity to owners and holders-in-due-course, denies injured parties their due process rights to establish their case against the defendant, and denies the injured party's due process rights to have the jury know about any findings that the court made on the evidentiary issues that may go against the defendant.

5. The bill's terms are contradictory and are thus, ambiguous at best. The proponents declare that SB 512 does not impact the workers compensation system or workers compensation claims. We note that the workers compensation laws would apply in work-related exposure cases and SB 512 would have no effect on the workers compensation "exclusive remedy" preemption. Yet SB 512 could possibly lead to absurd results because it broadly defines a workers compensation scenario by using the terms "occupational exposure for 5 years" and "occupational illness"; going to great lengths to define "employee"; and creating an exclusion using every known common-law descriptive phrase for independent contractors who would be third parties under the bill. We are hard pressed to identify a plaintiff other than an employee or independent contractor who would accumulate five years of work-related exposure as SB 512 requires.

Other difficulties with this bill are so technical and troublesome that we are not able at this time to recommend curative language or alternative legislation. Given the concerns raised by the proponents, and the additional concerns and implications of SB 512, we believe this issue requires more in-depth study and should be referred to an interim committee for further evaluation. We would be happy to work with committee members and the proponents in an interim setting to give this subject the attention it deserves but at this time we respectfully request that SB 512 not be passed.

Kan.. .s Association of Osteopathic M..dicine
1260 SW Topeka Boulevard
Topeka, Kansas 66612
Phone (785) 234 5563
Fax (785) 234 5564

Testimony on Senate Bill 512
House Insurance Committee
By Charles L. (Chip) Wheelen
March 14, 2006

We appreciate this opportunity to comment on SB512. We do not have a position either in support of or opposition to the bill. We are, however, concerned about certain definitions contained in section one.

As you probably know, under the Kansas Healing Arts Act and throughout the United States there are two types of physicians licensed to practice medicine and surgery; allopathic physicians (M.D.s) and osteopathic physicians (D.O.s).

Many physicians pursue board certification after they have completed their residency training in a medical specialty. Some physicians obtain additional training and also become certified in a subspecialty. There are two separate, but similar governing authorities that approve those medical specialty boards which are allowed to test applicants and grant subspecialty as well as specialty certification.

The governing authority established by the American Osteopathic Association is the American Osteopathic Bureau of Osteopathic Specialists. The AOBOS supervises 18 different certifying boards for osteopathic physicians. The governing authority established by the American Medical Association is the American Board of Medical Specialties. The ABMS supervises 24 different certifying boards for allopathic physicians. The Senate version of SB512 would recognize only those medical specialists certified by ABMS approved boards.

Our requested amendments would simply acknowledge that there are two parallel systems whereby a physician may become board certified in a particular field of medical expertise. A copy of our requested amendments is attached to this statement.

We respectfully request that you adopt our amendments prior to taking action on SB512. Thank you for your consideration.

House Insurance
Date: 3-14-06
Attachment # 22

Amendments to page one of SB512
Requested by Chip Wheelen
Kansas Association of Osteopathic Medicine

AN ACT enacting the silicosis claims act.

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

Section 1. As used in this act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them in this section:

(a) ''AMA guides to the evaluation of permanent impairment'' means the American medical association's guides to the evaluation of permanent impairment (fifth edition 2000) as in effect on the effective date of this act.

(b) "Board certified" means the physician is currently certified by one of the medical specialty boards approved by either the American board of medical specialties or the American osteopathic bureau of osteopathic specialties.

(c) ''Board-certified internist'' means a ~~medical doctor who is currently certified by the American board~~ physician who is board certified in the specialty of internal medicine.

~~(c)~~ (d) ''Board-certified occupational medicine specialist'' means a ~~medical doctor who is currently certified by the American board of preventive medicine in the specialty~~ physician who is board certified in the specialty of preventive medicine and the subspecialty of occupational medicine.

~~(d)~~ (e) ''Board-certified oncologist'' means a physician who is currently board certified ~~by the American board~~ in the specialty of internal medicine and in the subspecialty of medical oncology.

~~(e)~~ (f) ''Board-certified pathologist'' means a physician who is currently board certified ~~by the American board~~ in the specialty of pathology.

~~(f)~~ (g) ''Board-certified pulmonary specialist'' means a physician who is currently board certified ~~by the American board~~ in the specialty of internal medicine and in the subspecialty of pulmonary medicine.

~~(g)~~ (h) ''Certified B-reader'' means an individual qualified as a ''final'' or ''B-reader'' as defined in 42 C.F.R. section 37.51(b) as in effect on the effective date of this act.

~~(h)~~ (i) ''Civil action'' means all suits or claims of a civil nature in a state or federal court, whether cognizable as cases at law or in equity or admiralty. Civil action does not include any civil action:

(1) Relating to workers' compensation;

(2) alleging any claim or demand made against a trust established pursuant to subsection (g) of 11 U.S.C. section 524(g) as in effect on the effective date of this act; or

(3) alleging any claim or demand made against a trust established

[and re-letter ensuing subsections]

These amendments recognize there are two separate organizations which approve medical specialty boards that grant certification to those physicians (D.O.s and M.D.s) who have completed the necessary training and have successfully passed the required examinations.