Approved: 3-1-06
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 A.M. on February 21, 2006 in Room 234-N of the Capitol.

All members were present.

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

Conferees appearing before the committee:
Clint Patty, Frieden, Hayes & Forbes
Julie Hein, Kansas Pharmacy Coalition

Others attending:
See attached list.

The Chair said the Committee would continue hearings on (**SB 512**) - **An act enacting the silicosis claims act and (SB 522) - Concerning health insurance; providing the insured certain appeal rights regarding adverse health care decisions..**

The Chair asked Woody Moses to give an update as to what they are doing with the silicosis bill.

Mr. Moses said he would ask Clint Patty, legal counsel, to speak to this bill.

My name is Clint Patty. I am an attorney with Frieden, Haynes and Forbes, and I am here today on behalf of my client, both as an advocate and as a member of the Kansas Aggregate Assn.

Today the Association has offered a substitute for (**SB 512**) which the association believes both addresses and redresses the concerns that have been raised largely by the Kansas Trial Lawyers' Assn. The one point the association wants to emphasize to the committee today is that this is not a particularly unique bill or unusual bill or a drastic change, particularly the substitute that has been offered, to the way things operate now in at least four other states.

I know one of the previous concerns that had been raised is that this raises some constitutional crisis or some gigantic shift in the civil procedure code. In fact, this legislation mirrors and largely follows legislation that exists in other states where, as far as the association knows, there has been no great constitutional crisis and no great change, at least in the way people do business on a day-to-day basis, and how these items are litigated.

Really all the bill does is serve two purposes. One, it is an administrative gate to try to prevent the kind of abusive litigation practices that you have all read about that involve these silica cases. But secondly, and to the association and our industry's primary importance, is that it would allow at least the possibility that these folks can get insurance coverage which they cannot currently get because of the way the system is set up now.

There has been a great deal of testimony where people have talked about --Why do we need this bill? There is no crisis. Well, the association would submit that there is a crisis and the crisis is the inability to get insurance coverage for these claims. But I would also emphasis to this committee a second point. If you wait until these silica claims come to Kansas, then it is already too late. So, the bill really has two virtues. One, it is a forward-thinking bill that prevents this kind of abuse from ever coming to Kansas and it solves a very real and current problem, and that is the inability of members of our association to be able to obtain insurance coverage.

There are five very brief areas that I will touch on regarding the substitute. One, I don't believe there is a constitutional problem, particularly with the substitute. As I say, it mirrors legislation that exists in at least four other states. That constitutional problem does not seem to have arisen in any of those states. The

previous bill provided for 30 days for potential clients to present and an AMA diagnosis before they can proceed with their claim. The amendment now provides for 60 days, an additional 30 days in order to overcome the administrative gate that would exist with this particular bill. One other thing needs to be emphasized within this bill, if for whatever reason you do not provide an AMA recognized diagnosis of your claim within 60 days, your claim is dismissed, but it is dismissed without prejudice, meaning you can refile. You get a second, third, fourth, fifth bite of the apple. In fact, this particular bill provides the courts the opportunity to maintain jurisdiction, even over dismissed claims, so it is the association's thought that this is not a legitimate concern with this particular bill.

The other part that I would like to address is regarding experts and the alleged inability to use them. That is not the case in this bill and it wasn't the case in the former bill either. The only ban on the use of expert opinions or anyone's opinion regarding someone's diagnosis is that if it is an opinion that was generated either illegally or as a result of a medical ethics violation, if it was conducted without any kind of an established doctor-patient relationship -- in other words, no examination of the affected person or, third, if the expert opinion was only going to be given if someone would agree to legal representation. Other than that, folks can use whatever opinion they need to form the diagnosis and I think that is an important distinction and one provided in my previous written testimony before this committee.

Finally, the last section that I think needs to be addressed is this idea that there would be a great change in the piercing of the corporate veil which is an important principle. It has been in existence in Kansas Common Law for a long time. There was formerly in the bill a Section (9) which defined how you pierce the corporate veil in these cases. In my opinion, it didn't change a great deal the way Kansas courts have always dealt with it, but for simplicity purposes, that is all gone now. Section (9) has been eliminated and presumably these cases will be treated like any other case would be with regard to piercing the corporate veil in individual liability. With this substitute being offered today, and belief that the concerns that had been previously voiced have not only been addressed but redressed as well, it is the association's hope that this substitute (**SB 512**) will be passed into law, Mr. Patty said. (Attachment 1)

The Chair said she didn't intend to do any work on this bill today. I thought we would hear from Woody and Clint today and get an update on what we are doing and we will work it tomorrow, she said.

Senator Brungardt asked if Mr. Patty could address for him how this one employer/employee relationship and the class action suits against - what is the interface here?

Mr. Patty said he didn't think there was a great deal of interface other than for the most part, the employer/employee problems would be covered by workers' comp like they always have been. What this bill is primarily addressing is the mass class-action type suits and that is a different thing. It can cover anyone who has ever come in contact with silica exposure at all and claiming that suddenly they are affected and they need to be part of a large class action. The problem that has arisen in these areas we have called mass screening panels where you have doctors and lawyers sort of unscrupulously getting together and agreeing that anyone we find who has ever crossed a highway where road work is being done has had some exposure so why don't you check them as affected and we will include them in the class action. This particular bill puts a stop to that and the reason that is significant, it opens up, at least in the insurance industry's mind, the opportunity to insure our folks from being hit with this kind of claim. Even if they are frivolous, and you say you can always dismiss a frivolous case, the article that has been provided shows you an example of how one company had to pay about $17,000 in legal fees just to get frivolous claims dismissed. It is a costly venture that insurance is not willing to do and this bill would put a stop to it.

The Chair closed the hearing on (**SB 512**).

The Chair opened the hearing on (**SB 522**) - **concerning health insurance; providing the insured certain appeal rights regarding adverse health care decisions.** I think at this time there have been some amendments to be presented and asked Ken Wilke to explain the amendments to the bill.

Mr. Wilke said apparently the insert redescribes the process set forth in the first sentence. It just rewrites the first sentence so the health insurance policy has to include the procedures for obtaining internal review of an adverse decision. It specifies that the description has to include all applicable time periods, contact information, rights of the insured, and levels of the appeal. There is also added to subsection (a) a provision that requires the health insurance plan to provide the insured with written or electronic notification of any adverse decision, and a description of the review procedure and the insured's right to an external review as provided in K.S.A. 40-22a14.

In subsection (b) there has been some terminology change. Basically, we are reverting to "health insurance plan" rather than the "insurer's" and it requires that the insurance plan allow the insured to waive rights to the second appeal and in subsection © we've some language change that is consistent with what has gone before and in subsection (d) the main thing is the addition of the insert which would provide that any physician or other health care provider serving as a reviewer on the appeal panel or the internal review panel wouldn't be liable for any opinion that that person rendered as part of the appeal or internal review. Down in lines 39 through 42 that is basically rewriting of the existing language. On Page 2 on line 4 there is a provision added so that the person seeking review can also submit questions as well as the comments, documents and other materials. At the end of that there is also a provision that requires that the utilization review committee would provide answers to these questions within five business days of the day of the second review hearing.

Down in line 28 the reference to subsection (e) has been changed to subsection (a) presumably because that notice is now contained in the description referred to in subsection (a). Down in line 31 it puts a time frame on when the written decision has to be provided and then after line 38 we have a definition of adverse decision which is essentially the same as in the external review statute. It is basically anything that is adverse to the person who is seeking a review. (Attachment 2)

The chair said it was her intention to start at the beginning and gradually work through the bill.

The Chair said one of the questions was recording of the process. Does this balloon now, Ken, answer the recording process?

The recording process is still in the balloon on page 2, lines 20 and 21. It still allows the insured to record the proceeding at the insured's expense.

The Chair said that is one area where she has a big concern because from experience, it limits the ability to say anything. I know when we had due process hearings when I was on the school board we were advised to never say anything in open public because of what they can write down. So, my suggestion is that we take out lines 20 and 21 or #7. I would like to have some feedback.

Senator Allen said, obviously we did not strike that language, but we understand it is up to the committee.

Senator Brungardt said he understands the objection to recording on the basis that in an informal hearing or just an unfettered speech the ability to express opinions might somehow be inhibited with a recording, but is there some acceptable middle ground? If a statement is made as to the reason a decision is made on appeal – is it just denied and that's the end of the story? You really don't have any basis for discussion or examination of the panel's decision. You need some way of tracking what they were thinking or what their intent was.

Senator Allen said, this would be the only place where you could get a record of the hearing because when it goes to the external review, there is no hearing, so this would be the only opportunity to have any sort of a record of that hearing.

Senator Brungardt said, are you getting to the point that maybe there could be a written statement? Then you would have some basis for the decision that might take the place of the actual recording.

Larrie Ann Lower, representing Kansas Association of Health Plans, said what Senator Brungardt was referring to appears on Page 2 line 29 (g). 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 five business days of the hearing date.

The Chair asked if 20 and 21 are taken out, do they get a written response as to what happened in that meeting?

Senator Barone said this may not need to be a verbatim transcript, but maybe some minutes. I appreciate the need for a verbatim transcript or recording, but maybe some minutes – who appeared, what they said, what their position was, something like that, so the party asking for the review has some record of who said what and what their position was.

Senator Steineger said, it seems to me the way it is worded now, it is incumbent on the insured to record the proceedings themselves at their own expense. So I can't see what is so hard about allowing somebody to take a taperecorder or some type of a recording device.

The Chair said, the only problem is statements are used in court against anybody. I think this is what we are trying to get away from is somebody using what they said against them in a court of law.

Senator Steineger responded, conversely being held responsible for what they said. I feel no mercy for folks who do not want to be taperecorder.

The Chair said, I like what senator Barone said. I just think it will inhibit a good flow of information. I don't know maybe Senator Barnett can say something - do you have any apprehension about the recording?

Senator Barnett said, I guess I would compare it to peer review. I think if there is a lack of protection, there is going to be less candid discussion on something of a sensitive nature, I sort of fall in line with Senator Barone and have a compromise.

Senator Barone: I make a conceptual motion that we substitute for existing lines 20 and 21 words to the effect that minutes of record of the meeting detailing the parties position and a synopsis of their point of view. Senator Barnett seconded his conceptual motion.

Senator Brownlee asked if it is illegal for someone to record such a proceeding privately without anyone knowing it? With the recording devices available today, you could have an ipod with you and record it and nobody would know it.

Senator Barone said, there could be a statement prior to the meeting stating we are recording this meeting.

Senator Schmidt said on page 2, line 13, where it talks about 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. I had some questions – if a person preparing for that second hearing would have questions that they desire to have answered before they went to the hearing, I still believe that is very important and I believe we were given examples where that would have changed a person's tactic, if you were to go to the second hearing. I am wondering if there is some way that they could require that questions be answered in a certain time frame before the hearing rather than after the hearing?

Senator Allen responded that it takes the insured's position or attorney and people participating on the panel to gather all the information before they would be able to answer these questions. So you, the insured, Senator Schmidt, might ask a question that couldn't be answered until after the hearing. That is why the response doesn't have to be given until five days after the hearing date.

Senator Barnett asked Mr. Wilke to explain the second page "adverse decision" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

Mr. Wilke said that is referring to the statutory definition of adverse decision in the external review statute. In that statute an adverse decision is basically one that goes against the insured.

Senator Barnett moved the balloon on **(SB 522)** as presented by Senator Allen with the conceptual amendment proposed by Senator Barone. Seconded by Brungardt. Motion passed.

Senator Schmidt moved to move out (**SB 522**) with amendments. Senator Brungardt seconded. Motion passed.

The Chair said we will turn our attention to (**SB 547**) - **An act enacting the pharmacy benefits manager registration act.** The Chair introduced Julie Hein, representing the Kansas Pharmacists' Association and also the Kansas Pharmacists' Coalition and asked for comments. Ms. Hein reported they were able to meet with Bill Sneed yesterday and he proposed that he would remove opposition to the bill if we would remove Section (6a) that refers to the Unfair Trade Practices Act. After analyzing, we don't have a strong feeling about that, so we don't have a problem removing that language.

Ms. Hein said another thing that was asked in this committee was how many PBM'S there are nationally. We are researching that right now. Our preliminary information, as I think as Bill Sneed testified yesterday, finds there are five or six major PBM's nationally. We asked the insurance commissioner if she would be able to provide us a statement of support regarding the bill. We talked to John Campbell. I don't know if we'll have that in writing today, but maybe tomorrow. Right now, I'm authorized to support the version of (**SB 547**) that you three agree on.

The Chair said she would like to wait a while and see if KID has any problems with this bill.

Senator Schmidt asked Mr. Wilke to go over the amendment to (**SB 547**).

Mr. Wilke said, basically this amendment strikes subsection (a) of Section (6) which makes the pharmacy benefit manager subject to the Unfair Trade Practices Act of the insurance code. So basically what that would do is strike everything after Section (6) on line 38 through line 40 and subsection (b) on line 41 so Section (6) would read, "any person who acts as a Pharmacy Benefits Manager without being registered as required by this act should be subject to a fine of $500 for each action."

Senator Schmidt moved the amendment to (**SB 547**) as proposed. Seconded by Senator Wysong.

Chair opened for discussion. Motion passed. We will work the bill tomorrow and finish it up tomorrow.

Meeting adjourned at 10:30 a.m. The next meeting of this Committee is scheduled for February 22, 2006.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: February 21, 2006

NAME	REPRESENTING
Ramon Gonzalez	N.R. Hamm Quarry
Brad Hess	N.R. Hamm Quarry
John Meetz	KID
Cynthia Smith	SCL Health System
Andrew Couch	Federico Consulting
Lee Wright	Farmers Insurance
Bill Sneed	AHIP
Natalie Haag	Security Benefit
Susan Zalenski	Johnson & Johnson
Carol A. Liggins	AstraZeneca
Mandy Miller	Sen. Schmidt
Daniel R. Morin	Kansas Medical Society
[illegible]	KTLA
Eric Stafford	AGC Kansas
Scott Heidner	ACEC Kansas
[illegible]	KAPA
Clint Patty	Frieden, Haynes & Forbes
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TESTIMONY
By
Clinton E. Patty

Before the
Senate Committee on Financial Institutions and Insurance
Regarding SB 512

February 15, 2006

Chair Teichman, 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 rebuttal testimony to statements made on behalf of the Kansas Trial Lawyers Association, and to provide further 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

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specific concerns raised by the KTLA are fully addressed when viewing the bill as a whole. 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 30 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.

Finally, contrary to the KTLA's opinion, there is no "blanket immunity" for owners and holders in due course under the bill. SB 512 simply clarifies common law principals regarding "piercing of the corporate veil", and allows for individual owner liability if a three part test is met. Sec. 9. Therefore, SB 512 is not a radical departure from common law principals, and does not amount to "blanket immunity" for owners and holders in due course.

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.

PROPOSED AMENDMENT TO SB 522

Senator Allen

February 21, 2006

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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.~~ If the health insurer uses a utilization review organization, the insured shall be notified of the name of such utilization review organization.

Every health insurance policy 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.

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~~ 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.

(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~~.

(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.

(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:

(1) ~~Request, within five working days,~~ the opportunity to appear in

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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, 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;

(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.

(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~~).

(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.

(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.

(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.

questions

. 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

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within five business days of the hearing date

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

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2-1