Approved: February 28, 2007
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 20, 2007 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:
Dr. Steven Waldman, Headache & Pain Center, Overland Park; Phil Harness, Doctors' Hospital; Jeff VanHorn, Heartland Spine & Specialty Hospital; Kevin Robertson, Kansas Dental Assn.; Mary Ellen Conlee, Via Christi Health System; Daryl Thornton, Kansas Medical Center, LLC; Charles Wheelan, Osteopathic Assn.; and Dr. Bert Oettmeier, DDS, Proponents. Brad Smoot, BCBS; Doug Wareham, KBA; Kenneth Daniel, Kansas Small Biz; Matt Goddard, Heartland Community Bankers; Derrick Sontag, NFIB; Marlee Carpenter, Kansas Chamber; Patrick Patterson, HCA; Dean Newton, Delta Dental; Larrie Ann Lower, KAHP, Opponents.

Others attending:
See attached list.

The Chair called the meeting to order.

Hearing on:

SB 175 - An act concerning health insurance; relating to assignment of insurance payments for covered services.

Melissa Calderwood gave an overview of the bill. She stated that this act shall be known as the expanded access to health care act. All policies and certificates providing benefits for medical care issued on or after July 1, 2007, must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy or certificate. She stated when any insurance entity has notice of such assignment prior to such payment, any payment to the insured shall not release such entity from liability to the provider to which the benefits have been assigned, nor shall such payment be a defense to any action by the provider against that entity to collect the assigned benefits. She said this act shall take effect and be in force from and after its publication in the statute book.

Steven Waldman, M.D., testifying in support of SB 175 said this bill will benefit the patient while at the same time allowing Blue Cross Blue Shield the same rights as every other insurance company that does business in Kansas. This includes the right to offer the types of insurance they choose to sell and the right to pick which providers they want in their network. SB 175 simply requires Blue Cross Blue Shield to act like all other insurance companies and be required to honor valid and legal assignment of insurance benefits freely entered into between the patient and their healthcare provider. (Attachment 1)

Philip Harness, CEO, Doctors Hospital, LLC, testified in support of SB 175. Mr. Harness said this bill seeks to accomplish a public and consumer oriented purpose, that of honoring assignments by patients of their financial benefits under the "out of network" provisions of their health insurance policies. This has the unique effect of expanding access to the spectrum of health care in Kansas. Mr. Harness said the current state of affairs is proving harmful not only to health care providers, but also their Kansas patients. (Attachment 2)

Jeff VanHorn, CFO for Heartland Spine & Specialty Hospital in Overland Park, Kansas, testified in support of SB 175. Mr. VanHorn said that it was his sincere hope that the insurance industry will offer an alternative solution to this matter should they speak in opposition to this legislation. He said this problem is faced by numerous hospital facilities and physicians and that he was seeking a solution. (Attachment 3)

MINUTES OF THE Senate Financial Institutions and Insurance Committee at 9:30 A.M. on February 20, 2007 in Room 234-N of the Capitol.

Kevin Robertson, CAE, Kansas Dental Association, testified in support of SB 175 regarding the issue of insureds having the right and ability to assign their insurance benefits to a provider of medical care. The KDA requests that line 15 of the bill be amended after "medical" to include the words "or dental". (Attachment 4)

Mary Ellen Conlee testified on behalf of Michael Wegner, Chief Financial Officer, Via Christi Regional Medical Center. Mary Ellen said SB 175 is about eliminating the bad debt and unnecessary legal action that the refusal of assignment of benefits policy has foisted on medical providers in Kansas. She said the courts have repeatedly found that the decision to allow insurers to engage in the practice of refusing to honor assignment, despite the unnecessary costs to providers, is a public policy decision and can only be corrected by the Kansas Legislature. (Attachment 5)

Written testimony of Daryl Thornton, Chief Operating Officer for the Kansas Medical Center, LLC; Charles L. Wheelen, Kansas Association of Osteopathic Medicine; and Dr. Bert W. Oettmeier, Jr., D.D.S., is attached supporting SB 175. (Attachments 6, 7, and 8)

Brad Smoot, Legislative Counsel for Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Kansas City, testified in opposition to SB 175. Mr. Smoot said that providers who contract with BCBS agree to accept reimbursement as full payment. That means BCBS gets to have some say in what health care services cost. He said BCBSKS contracts with virtually all doctors and hospitals in Kansas. SB 175 is not a burning issue for those providers. More importantly, employers and employees are the beneficiaries of contract negotiations and provisions limiting balance billing. They would be the big losers if SB 175 were to pass. (Attachment 9)

Doug Wareham, Kansas Bankers Association, testified in opposition to SB 175. Mr. Wareham stated SB 175 would require non-contracting providers to be paid directly by the insurance company. That would clearly erode the providers' incentive to contract with insurance companies. Thus, insurance companies wanting to maintain an adequate network of providers would be forced to increase their reimbursement to encourage participation, and that would result in even higher health insurance premiums for individual Kansans. (Attachment 10)

Mr. Kenneth L. Daniel, Kansas Small Biz, testified in opposition to SB 175. Mr. Daniel said this bill would result in providers insisting on a bigger chunk of the consumer's dollar, but the consumer will be completely left out of the negotiation. He testified that another unacceptable aspect of this bill is that it can force insurance companies to pay twice or more for the same transaction simply because a complicated red tape procedure is not tracked. He said the cost of that red tape procedure and the double payments will run up health insurance costs with absolutely no benefit to the patient. (Attachment 11)

Written testimony of Matthew Goddard, Heartland Community Bankers Association; Derrick Sontag, Kansas State Director, NFIB; Marlee Carpenter, Vice President of Government Affairs, the Kansas Chamber; Patrick L. Patterson, Vice President, Managed Care, HCA; Dean Newton, Vice President, Sales and Marketing, Delta Dental of Kansas and Larrie Ann Lower, Kansas Association of Health Plans is attached in opposition to SB 175. (Attachments 12, 13,14, 15, 16, and 17)

Following discussion, the Chair closed the hearing.

Action on:

SB 255 - concerning insurance; pertaining to the use of lapsed rates.

Senator Schmidt moved to approve SB 255 as amended. Senator Barnett seconded. Motion passed.

Senator Barnett moved to advance the bill favorably as amended. Senator Schmidt seconded. Motion passed.

Action on:

SB 273 - concerning insurance; related to the prompt payment of certain claims.

MINUTES OF THE Senate Financial Institutions and Insurance Committee at 9:30 A.M. on February 20, 2007 in Room 234-N of the Capitol.

Senator Steineger moved to approve SB 273 as amended. Senator Brownlee seconded. Motion carried.

Senator Steineger moved to advance the bill favorably as amended. Senator Brownlee seconded. Motion carried.

The meeting adjourned at 10:30 a.m.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: 2-20-07

NAME	REPRESENTING
Alex Kotoyantz	P.I.A
KEVIN ROBERTSON	KS DENTAL ASSN
Robert Waller	KBEMS
Dave Cromwell	KBEMS
Laurie Ann Lower	KA HP
John Beetz	KID
Dick Cook	KID
KEN DANIEL	KS SMALL BIZ. COM
Steven Weltman, MD	Medical Practitioners
Phil Hartnett	Doctors Hospital LLC
Allison Peterson	Kansas Medical Society
JEFF VANHORN	Heartland Spine & Specialty
Doug Wareham	KBA
Kathy Olsen	KBA
Kerri Spielman	KAIA
Larry Magill	KAIA
Will Deer	Federico Consulting

Testimony before the Senate Committee on Financial Institutions and Insurance
Senate Bill No. 175
February 20, 2007

By: Steven Waldman. M.D.
4801 College Blvd.
Leawood, KS 66211

To the Chair and Members of the Committee:

Senate Bill No. 175 is not about Blue Cross Blue Shield…….it is not about the physicians, dentists, podiatrists, chiropractors, other licensed healthcare professionals, and hospitals who provide healthcare in our State……..it is very much about and for the **PATIENT**! I am here testifying today first and foremost as an advocate for my patients. I am here to urge the Chair and Members of this Committee to do what is right for the patient…….because it is the patient who is being harmed by the status quo and Senate Bill No. 175 will remedy this harm.

How is the patient being harmed by the status quo? Under the current law, Blue Cross Blue Shield and only Blue Cross Blue Shield is provided statutory relief afforded to no other insurer who does business in Kansas. Current Kansas law allows Blue Cross Blue Shield to refuse to honor an assignment of insurance benefits freely entered into between the patient and their doctor or hospital……an assignment that would otherwise be valid and legal and recognized by every court in this state. This special treatment afforded Blue Cross Blue Shield places the patient seeking to obtain care from an out of network physician or hospital at an extreme disadvantage when compared with patients

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insured by insurance companies besides Blue Cross Blue Shield. They are disadvantaged because:

1. These patients pay Blue Cross Blue Shield extra money to obtain a policy that provides an out of network benefits provision. Blue Cross Blue Shield sells many policies that do not have this provision and this Bill does not seek to impair their right to do so. Some patients feel strongly about their right to choose to receive care from a specific physician or hospital. Such patients choose to pay Blue Cross Blue Shield extra money to ensure that they have the guaranteed right to seek access to care from any physician or any hospital regardless of whether Blue Cross Blue Shield allows them to be in their network. Patients pay this extra money because they want the right to seek care from the physician or doctor they deem can best take care of their healthcare needs. This might be a family physician of longstanding, a pediatrician or caring obstetrician, or in the case of a critically ill patient, the right to seek a physician with special expertise or a hospital with a special service such as a transplant team or burn unit.

Yet, although Blue Cross Blue Shield charges them extra for this right, they make it almost impossible for the patient who has paid this premium for this guaranteed access to get it. I must emphasize to the Chairman and Members of this Committee that it is in almost all instances that it is Blue Cross Blue Shield who chooses whether or not to allow a physician or hospital to be an in-network provider with Blue Cross, not the physician or hospital. This is important in that when Blue Cross Blue Shield refuses to honor an assignment of insurance benefits between the patient and the out of network physician and/or hospital, it essentially makes the out of network

provision which guarantees the patient the right to see out of network providers that the patient paid extra for essentially worthless. The out of network provision is worthless due to the fact that the physician or hospital knows that they have little or no chance of being paid for the care they provide because Blue Cross Blue Shield can ignore any assignment of insurance benefits freely entered into between the patient and the physician or hospital. I must emphasize that this right to ignore an otherwise valid and legal assignment of benefits is a special and unique status conferred on Blue Cross Blue Shield by current Kansas law. This is a benefit afforded no other insurer doing business in the State of Kansas. When a physician or hospital sees a patient on an out of network basis and the patient and provider executes a valid and legal assignment of benefits, all other insurance companies other than Blue Cross Blue Shield must under Kansas law honor the assignment and must pay the physician or hospital directly. The fact that Blue Cross Blue Shield can ignore a perfectly valid and legal assignment exerts an extreme chilling effect on the number of providers who are willing and able to see Blue Cross Blue Shield patients on an out of network basis. In essence, Blue Cross is selling the patient an insurance policy and charging the patient extra money for a provision that guarantees that the patient can have the choice and access to the care they want (and are willing to pay extra for) and then by not having to honor a valid and legal assignment of benefits and paying the out of network provider directly, it makes it essentially impossible for the patient to find a provider that can afford to accept the out of network patient. It should be remembered that our current law allows Blue Cross Blue Shield to create this situation which harms the patient by first refusing to allow any willing provider to be

in-network and then forcing them into an out of network status that they do not want.....and then refusing to honor an otherwise valid and legal assignment of benefits to pay the provider directly. This situation obviously benefits only Blue Cross Blue Shield while doing nothing to benefit the patient, the provider, or the citizens of Kansas. Senate Bill 175 will remedy this fundamentally unfair situation while at the same time leaving Blue Cross Blue Shield to free continue to limit physicians, dentists, podiatrists, chiropractors and hospitals access to in-network status in their network and free to continue to write insurance policies that provide no out of network benefits for those patients that do not want them. All Senate Bill 175 does is to require that Blue Cross Blue Shield honor valid and legal assignments of insurance benefits between providers and their patients just like all other insurance companies doing business in the State of Kansas.

2. The status quo also harms patients who seek to use the out of network provisions that they paid for because under current law, Blue Cross Blue Shield does not have to honor an otherwise valid and legal assignment of benefits. This means that Blue Cross Blue Shield can refuse to talk directly with the out of network provider regarding the patient's insurance benefits. They justify this harmful behavior citing that because they do not have to honor the assignment, that there is no privity of contract between the provider and Blue Cross Blue Shield. This leaves the patient to fend for themselves when trying to figure out the complex maze of insurance paperwork, explanations of benefits, denials of care provided, etc. The complexity of the current insurance situation places the patient at an extreme disadvantage when trying to figure out what Blue Cross Blue Shield did or did not pay for. Under <u>any</u>

other out of network situation with any other insurance company who does business in Kansas, when there is a legal and valid assignment of benefits, the patient can turn to the provider for help and the provider can deal directly with insurance company and help get the patient the answers they need. Furthermore the provider, armed with special knowledge of both medicine and the complexities of insurance can serve as a patient advocate to ensure that the insurance company is forced to actually provide the benefits that the patient paid for…….something that the patient is often ill equipped to tackle on their own. Under current Kansas, this is not the case with Blue Cross Blue Shield. Blue Cross Blue Shield can remove the provider from their traditional role as patient advocate by simply refusing to talk with them. This makes it impossible for the provider to serve as a patient advocate. Senate Bill 175 remedies this harmful situation and simply requires Blue Cross Blue Shield to do what every other insurer who does business in Kansas is required to do…..talk to the provider who provided the care. Again, Senate Bill 175 does not prevent Blue Cross Blue Shield from writing insurance that provides for no out of network benefits and does not prevent them from excluding willing providers from in-network status. Senate Bill 175 simply corrects a situation that harms the patient.

3. I have talked much about patient choice, but it is important to acknowledge that there are many situations where the patient does not get to choose their health care provider. These are situations that are thrust on the patient……car wrecks, fires, heart attacks, acute illnesses, etc. In these situations, which occur every day, the urgent circumstances surrounding the patient's health may mean that they are forced to receive care from providers that Blue Cross Blue Shield has chosen to exclude form its network.

These providers unfailingly do what is required of them with little assurance that they will be paid. Although other insurance companies doing business in the Kansas are required by law to deal directly with the provider to resolve such disputes, Blue Cross Blue Shield can simply refuse to talk with the provider, making resolution next to impossible.....leaving the patient or his or her family or estate to sort things out.

Although Kansas law requires that insurance companies pay for emergency care without regard to in-network status, frequently, the insurer will refuse to pay the claim stating that the care was not emergent in nature even though the patient and provider thought that it was an emergency. Again, other insurance companies must deal directly with the provider while Blue Cross Blue Shield can simply refuse to do so. Senate Bill 175 will remedy this fundamentally unfair situation and require all insurance companies to work with all providers to resolve issues surrounding emergency care.

In summary, Senate Bill 175 will benefit the patient while at the same time allowing Blue Cross Blue Shield the same rights as every other insurance company that does business in Kansas. This includes the right to offer the types of insurance they choose to sell and the right to pick which providers they want in their network. Senate Bill 175 simply requires Blue Cross Blue Shield to act like all other insurance companies and be required to honor valid and legal assignment of insurance benefits freely entered into between the patient and their healthcare provider.

Testimony before the Senate Committee on Financial Institutions and Insurance
Senate Bill No. 175
February 20, 2007

By: Philip S. Harness, C.E.O.
Doctors Hospital, L.L.C.
4901 College Blvd.
Leawood, KS 66211

To the Chair and Members of the Committee:

Senate Bill No. 175 seeks to accomplish a public and consumer oriented purpose, that of honoring assignments by patients of their financial benefits under the "out of network" provisions of their health insurance policies. This has the unique effect of expanding access to the spectrum of health care in Kansas.

Traditionally, Kansas has recognized the ability of a payee under a contract to assign that particular right (of payment) to another. This is true of almost any scenario wherein the payment of money by a third party is offered as an inducement by a party to perform a contract. However, in the health care arena, this ability has been abrogated by contractual language imposed by one insurer in particular, Blue Cross and Blue Shield of Kansas City, Inc., a Missouri corporation, which is in charge of the provider contracting for Blue Cross and Blue Shield in Johnson and Wyandotte counties. However, other states have faced this same issue and have maintained the position of honoring the assignment of "out of network" benefits by an insured to the health care provider.

Health care providers tend to want to be in contract with as many health care networks as possible (so long as the reimbursement is feasible), both for convenience of the patient, as well as a guarantee that the payment will flow to the health care provider directly from the insurer using that particular network. However, many health care providers (both doctors and hospitals) have been precluded from joining the network of Blue Cross and Blue Shield of Kansas City, under the guise that its network panels in that specialty (in the case of doctors) or its network of hospitals, are full. As a means of punishing the patient who goes outside of the network, and punishing the health care provider who has not been fortunate enough to contract with Blue Cross and Blue Shield to be in its network, Blue Cross and Blue Shield of Kansas City imposes a contractual provision that it will not recognize any assignment of benefits (payments) to the

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out of network provider, and instead that fee (or the portion that is allowable) will be paid to the patient, which means the health care provider will be required to "chase" the fee.

Once the fee is given to the patient, in some instances (albeit rare) the patient will tender that over to the health care provider, but often the health care provider is left in the unenviable position of having to take legal action against the patient. This leads to a breakdown in the special bond between the health care provider and the patient. The insurer refuses to tell the provider how much it has paid the patient (whatever their allowable charges are against actual billing), or when it was paid. At Doctors Hospital, LLC, we have had to file multiple actions (lawsuits) against patients in an attempt to collect the insurance checks that were assigned to the hospital by the patient before care was provided, and then converted by the patient to their own use after care was provided.

Other states which follow the more traditional route of honoring assignments do not have this issue to deal with. South Dakota recognizes the right and ability of a patient to assign benefits in Sections 58-17-61 and 58-11-36 of its statutes.

Section 2 of Senate Bill No. 175 follows Sections 2755 and 2827-A of the statutes of the State of Maine, which requires that all medical and dental care policies must contain a provision permitting the insured to assign benefits for care to the provider of the care, and those assignments do not affect or limit the payment of benefits otherwise payable under the policy.

Section 3 of Senate Bill No. 175 follows Section 40:2010 of the statutes of the state of Louisiana, in that if the insurance company has notice of the assignment, then that payment shall go to the health care provider and any payment to the patient shall not release the insurance company from liability to the care provider.

In the usual scenario, the patient has executed an assignment of benefits, this bill just gives credence to that assignment. The patient and the health care provider have already determined that the business aspect of the transaction shall be handled in that manner, it just requires the insurer to recognize the assignment.

This Committee sits in the unusual position of having a greater degree of knowledge of insurance law and requirements than that of most Kansans. The current state of affairs (not recognizing assignment by

the patient and even precluding it by contract) is proving harmful not only to health care providers, but also their Kansas patients, by this insurance lobby imposed requirement. To recognize assignments and the ability of the patient insurance subscriber to assign does not hurt the networks of health care providers, nor does it hurt the insurance company; the checks would be in the same amount, right to the penny, and the explanation of benefits given to the patient would match that explanation of benefits given to the health care provider. Communication of costs and payments would be restored, lessening both the cost burden as well as the administrative burden on the patients.

Jeff VanHorn's Statement Supporting
SB 175

Mr (Ms.) Chairman and distinguished committee members, my name is Jeff VanHorn and I am the Chief Financial Officer for Heartland Spine & Specialty Hospital in Overland Park, Kansas. The hospital is a small 19 bed Hospital facility with 7 Operating suites and a Pain Management program.

The facility has state of the art diagnostic radiology capabilities and all private rooms. The facility has been opened and state certified as a General Hospital since September 2003 where the patients treated have experienced less than .77% infection rate to every 100 surgeries performed at Heartland Spine & Specialty Hospital. Another quality indicator the "Length of Stay" is well below the national average based on the acuity of other like Hospitals.

During the course of the hospital's existence there has been an attempt to contract with all managed care plans. The hospital participates in both Medicare and Kansas and Missouri Medicaid programs. Heartland follows all of the guidelines informing patients upon admission that there are "assignment of benefits" in place to ensure payment is paid to provider. Over the course of the hospitals existence the healthcare market is such that we have been invited to participate as a provider for some insurance companies and are not considered a provider of some insurance companies. I would say this is relatively normal for all hospitals.

Some patients with plans that we are not a net work provider for still choose to utilize the hospitals state-of-the-art facility and first class technology. Only one insurance company currently operating in the State of Kansas has decided not to honor an assignment of benefits for out-of-network patients. In the vast majority of cases

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regardless if I am in network or out-of-network the insurance carrier will pay the hospital directly for services rendered. However, Blue Cross and Blue Shield is the only carrier that has decided to send our reimbursement check directly to the patient.

Since the inception of the hospital, Blue Cross & Blue Shield net revenues are approx $4.9M and make up about 6.5% of the Total hospital's revenue stream. We have had numerous successes in obtaining payment from the patient when the explanation of benefits and the facility check was mailed to the patient. There have been however, a total of $1.6M or 32% of the entire Heartland BCBS Revenues that have not been collected from the patient because the assignment is not recognized by BCBS and patients are depositing the checks into their own personal accounts.

I have literally had several patients tell me that they spent our checks on vacations to Disney World. Last week we had a patient blow our $50,000 at the craps tables in Vegas. New boats and new cars seem to be the most common use of this money.

The facility has had to hire collections staff exclusively to attempt to collect payment that BCBS has paid to their enrollee and the also has used any legal means to alert the patient of their obligation that BCBS will be sending the payment due the hospital to them and to forward all correspondence as well as the payment to the facility once they receive the amount. Just recently within the last few weeks BCBS has again attempted to make collections further problematic to non-participating providers and closed the access on their web page for the facility to check when the payment was sent to the patient for the follow up process.

The physicians of our hospital feel they should not have to be in the business of hiring bill collectors and lawyers to harass patients they just treated. I am sure we can all appreciate that this situation

really creates a damper on doctor patient relationship in these cases.

For a hospital this size $1.6M is a cash flow problem that cannot continue to absorb. As late as last Monday I received a call from a Third Party Administrator discussing a settlement on a Blue Cross/Blue Shield patient and the ending point of the conversation is that we will send the check directly to the facility rather than the patient as a caveat to settle the account.

The reason I am here before you today is because BCBS attorneys like to recite the statute this legislation is effecting as the reason they are sending our reimbursement checks to patients. It seems to me the only reason for this decision is to make out-of-network providers jump through so many hurdles to discourage them from treating BCBS patients. This seems to limit a Kansans ability to choose their provider.

The facility has provided approximately 144 employees with full time employment. During the time the hospital has been open there has been 23,254 patients in a combination of Surgeries, Pain Clinic visits, and Radiology. It is our mission to continue to provide a quality hospital and service lines and to allow all patients access. Any consideration your committee would recommend to introduce for vote of the "assignment" bill would be appreciated as this would help stop the abundance of resources the hospital has committed to a level in excess $250,000 in assignment collections for services rendered for each patient's time of need.

It is my sincere hope that since only one insurance company seems to be using these ugly tactics, that the insurance industry will offer alternative solution to this matter should they speak in opposition to this legislation. This problem is faced by numerous hospital facilities and physicians I come seeking a solution to this problem.

Thank you for your consideration. I now submit myself to the questions of this distinguished committee.

KANSAS DENTAL ASSOCIATION

Date: February 20, 2007

To: Senate Committee on Financial Institutions and Insurance

From: Kevin J. Robertson, CAE
Executive Director

RE: Testimony on SB 175 (Assignment of Benefits)

Chairman Teichman and members of the Committee I am Kevin Robertson, executive director of the Kansas Dental Association (KDA) representing 1,168, or some 80% of the state's licensed dentists. I am here today to **support SB 175** regarding the issue of insureds having the right and ability to assign their insurance benefits to a provider of medical care. The KDA would request that line 15 of the bill be amended after "medical" to include the words *"or dental."*

The KDA strongly supports the rights of insureds to assign their insurance benefit to providers who do not participate in certain insurance networks. SB 175 does not require insureds to assign their insurance benefits to these providers, but it does require insurance companies to give insureds the option to assign their benefits if they choose to do so. Covered and allowable services, as well as the reimbursement rates for services would remain the decision of the insurance carrier. The insurance carrier would owe the same reimbursement to their insured – the only difference is where the insurance check might be sent.

The KDA has difficulty following the logic that giving insureds the right to assign their insurance benefits will reduce provider networks and increase the cost of healthcare. Insurance carriers will still have significant leverage to create incentives for their insureds to stay "in-network" as their insureds who acquire healthcare services from "out-of-network providers" will still be required to pay the full cost of the treatment with usually a lesser reimbursement for the same services rendered. While many factors play into the selection of a dentist by a patient including reputation, personality and practice location - the financial consideration is often the strongest and only consideration for a patient. Be that as it may, some insureds will seek out providers for the other reasons mentioned. It is these patients that would be affected by SB 175 as currently their right to assign money that is owed them is being denied.

Thank you for your time today. **I urge you to support SB 175.**

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5200 SW Huntoon • Topeka, KS 66604 • 785.272.7360 • FAX 785.272.2301 • kevin@ksdental.org

Via Christi Health System

TESTIMONY PRESENTED TO
SENATE FINANCIAL INSTITUTIONS AND INSURANCE
By Michael Wegner, Chief Financial Officer
Via Christi Regional Medical Center
February 20, 2007

Good morning, my name is Mike Wegner, CFO of Via Christi Regional Medical Center in Wichita, Kansas. I am addressing the committee in favor of SB 175 to achieve two positive results:

- Settle a conflict regarding "free assignability" in insurance policies that exists in Kansas statutes
- Reduce our cost of doing business by $800,000 to $1,000,000 per year

Legal considerations:

The basic rule in Kansas insurance law found in K.S.A. 40-439 allows a policy owner to assign his or her rights to another person or legal entity. As a normal practice in hospital admissions paperwork, patients agree to the procedures associated with billing their insurance companies, part of which is assigning direct payment to the medical provider. For your reference, see the text of this statute at the end of this testimony.

About 10 years ago, Blue Cross transitioned to a mutual insurance company and simultaneously made a decision to limit the number of hospitals that it would contract with in the Wichita, Kansas marketplace. As part of this transition, Blue Cross proposed, and the legislature approved, a technical amendment to K.S.A. 40-19c06(b) which allowed Blue Cross to remain exempt from the established public policy of "free assignability" outlined in K.S.A. 40-439. For several years after passage of the technical amendment, the Kansas Insurance Department interpreted the language as applicable only in Blue Cross health insurance policies and denied others the ability to deny assignment, holding them to the "free assignability" requirements of K.S.A. 40-439.

As HMOs authorized under different enabling legislation became a more popular health insurance product, the Kansas Insurance Department allowed companies to deny assignment in HMO policies. HMOs do not promise subscriber choice, but instead require physician approval of out of network providers.

Then, in 2004, based on a legal opinion from the Insurance Department Counsel that relied on an interpretation of federal case law, the ability to deny assignment of benefits was extended to all health insurers provided the refusal to assign benefits was used for

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cost containment. The cost containment strategy is apparently evaluated by the Kansas Insurance Department at the time the Department approves any filing that includes a denial of assignment to non-contracting providers.

Therefore in 2004, a Via Christi Health System insurance company, Preferred Health Systems (PHS), sought and received approval from the Insurance Department to include non-assignment clauses in its insured contracts that essentially deny assignment of claim payments to health care providers who would not sign contracts. Preferred Health Systems currently uses this tool to assure it is on a level playing field with its competitors with respect to its provider contracting activities. Via Christi Health System asks that you return Kansas to the rule of "free assignability" of insurance benefits. If the legislature acts to support SB 175, PHS will not oppose prohibiting the practice of denying assignment in its policies, because a level playing field in the insurance marketplace would be preserved.

Financial considerations:

As a result of the Blue Cross refusal to assign benefits to Via Christi Regional Medical Center, since 1993 our cost of doing business has increased each year between $800,000 to $1,000,000 due to lost revenue associated with increased collection costs and the outright refusal of Blue Cross beneficiaries to remit the checks they receive from Blue Cross for their care to the hospital. This practice, sanctioned by K.S.A. 40-19c06(b) and current Insurance Department policy, has resulted in costly litigation and unnecessary bad debt for Via Christi and an unjust enrichment for some patients.

You may hear that the refusal to honor assignment is a negotiating tool needed to encourage providers to contract with Blue Cross. A contracting provider is bound by utilization policies and procedures that control medical costs. Via Christi already contracts with Blue Cross for emergency room, burn, organ transplant and psychiatric services and has, thereby, demonstrated its willingness to accept these utilization policies and procedures. While St. Francis Regional Medical Center and St. Joseph Medical Center both refused to respond to a Blue Cross RFP 10 years ago, since that time, Via Christi Regional Medical Center, the merged entity of St. Francis and St Joseph Medical Centers, has indicated its desire to participate in a full service contract with Blue Cross each time the opportunity has been presented.

To evaluate the merit of allowing "non-assignment" as a negotiating tool, one needs to step back and consider what a PPO, a Preferred Provider Organization, promises its subscribers. This type of insurance product identifies specific preferred providers and encourages subscribers to utilize those providers. Even so, the contract with the subscriber specifically allows the subscriber choice to utilize other providers, while at the same time discouraging the practice by penalizing the subscriber through use of a reduced payment amount or "penalty" for the services received from a non-contracting hospital or medical provider. PPO policies promise choice, but financially encourage their subscribers to stay within the panel of approved providers. In the Via Christi case,

the decision by Blue Cross to refuse its subscribers the right to assign payment to the medical center is an attempt to force Via Christi to refuse to provide medical services to Blue Cross subscribers who choose to use our facility. Please note, one more time, that a PPO policy promises that choice with a financial penalty to its subscribers who nonetheless opt for that choice.

You may hear that insurers have negotiated millions of dollars in savings from Kansas medical providers as a result of this statutory authority to refuse direct payment of benefits to non-contracting medical providers. I would counter that argument by pointing out that the real savings come from strict adherence to utilization policies and procedures and negotiated prices. The contract between an insurer and its subscribers dictates the amount of payment that will be made for services provided by non-contracting medical providers. By paying that amount directly to the non-contracting provider, the insurance company would be paying less, not more for the services.

For Via Christi Regional Medical Center, SB 175 is about eliminating the bad debt and unnecessary legal action that the refusal of assignment of benefits policy has foisted on medical providers in Kansas. The courts have repeatedly found that the decision to allow insurers to engage in the practice of refusing to honor assignment, despite the unnecessary costs to providers, is a public policy decision and can only be corrected by the Kansas Legislature. We ask for your support.

Thank you for giving us this opportunity to present our case to you. I would be happy to answer questions.

****

K.S.A. 40-439:

No provision in K.S.A. 40-434 and 40-435 or any other law shall be construed as prohibiting a person whose life is insured under a policy of group life or accident and health insurance or the policy owner of an individual life or accident and health policy from making an assignment of all or any part of his rights and privileges under such policy including specifically, but not by way of limitation, any right to designate a beneficiary or beneficiaries thereunder and any right to have an individual policy issued to him in accordance with subsections (8), (9) or (10) of K.S.A. 40-434 and 40-435. Subject to the terms of the policy relating to assignment of such rights and privileges thereunder, such an assignment by an insured or the policy owner, made either before or after the effective date of this section, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such rights and privileges so assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue in accordance with subsections (8), (9) or (10) of K.S.A. 40-434 and 40-435 prior to receipt of notice of the assignment.

WRITTEN TESTIMONY OF DARYL THORNTON
SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
SENATE BILL NO. 175
FEBRUARY 20, 2007

Dear Chairperson Teichman and Committee Members;

Thank you for the opportunity to submit written remarks on Senate Bill No. 175. My name is Daryl Thornton. I currently serve as Chief Operating Officer for the Kansas Medical Center, L.L.C.

Kansas Medical Center, L.L.C. is a licensed 58-bed general acute care hospital in Andover, Kansas. Our new facility offers state of the art medical services, with 24-hour physician, nursing and emergency room services. We opened our doors to the community on October 2, 2006.

I appear here today in support of Senate Bill No. 175 and I urge the Committee to pass this proposed legislation.

Senate Bill No. 175 requires insurance policies that provide coverage and benefits for health care also contain provisions allowing the insured to direct payments to health care providers.

As a start up hospital we are still in the process of establishing our place in the community and working on access to existing insurance networks.

We estimate 34% of our annual gross revenues/reimbursements will be through insurance companies. We also estimate 50% of these payments will go directly to the patient and a majority of those payments received by the patients will be "cashed and pocketed" by these patients. As a result, our facility will need to allocate resources, generally 1 FTE, toward the extensive and expensive activity of collecting of these accounts in an effort to recover payment for the services we have provided.

Senate Bill No. 175 would allow us to devote more effort and energy toward providing quality patient care. Freeing up valuable resources that could be targeted for more efficient patient care.

I urge you to act favorably on this legislation.

Thank you for your time this morning.

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2-20-07
Attachment 6

Kansas Association of Osteopathic Medicine
1260 SW Topeka Boulevard
Topeka, Kansas 66612
Phone (785) 234 5563
Fax (785) 234 5564

Statement in Support of Senate Bill 175
Senate Financial Institutions and Insurance Committee
February 20, 2007
By Charles L. Wheelen

We appreciate the opportunity to express our support for patient rights legislation. We support the provisions of SB175 because they would reinforce the principle of patient freedom of choice, and would promote continuity of medical care for patients who have an established relationship with a physician.

Over the years our Legislature has repeatedly sought to protect the interests of Kansas consumers of health insurance. For example, in 1969 the Legislature enacted K.S.A. 40-439 which is intended to assure that consumers of both life insurance and health insurance may assign the benefits of their insurance policy.

> **40-439. Assignment of rights and privileges under life and accident and health insurance policies.** No provision in K.S.A. 40-434 and 40-435 or any other law shall be construed as prohibiting a person whose life is insured under a policy of group life or accident and health insurance or the policyowner of an individual life or accident and health policy from making an assignment of all or any part of his rights and privileges under such policy including specifically, but not by way of limitation, any right to designate a beneficiary or beneficiaries thereunder and any right to have an individual policy issued to him in accordance with subsections (8), (9) or (10) of K.S.A. 40-434 and 40-435. Subject to the terms of the policy relating to assignment of such rights and privileges thereunder, such an assignment by an insured or the policyowner, made either before or after the effective date of this section, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such rights and privileges so assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue in accordance with subsections (8), (9) or (10) of K.S.A. 40-434 and 40-435 prior to receipt of notice of the assignment.

This law is based on a fundamental premise that the benefits of an insurance policy are owned by the insured; not the insurer nor a third party that purchased the insurance on behalf of the insured. We support that premise and believe it should be the foundation for your public policy decisions regarding regulation of health insurance.

A few years later the 1973 Legislature decided it was in the best interests of health insurance consumers to enact two laws designed to assure patient access to their choice of health care professional. These statutes are sometimes referred to as "non-discrimination" laws because they establish that if the insurance policy provides coverage for a service that is within the statutory definition of the practice of any branch of the healing arts, and services are provided by a licensed health care professional within his or her scope of practice, then reimbursement or indemnification cannot be denied by the insurer.

> **40-2,100. Insurance coverage to include reimbursement or indemnity for services performed by optometrist, dentist or podiatrist.** Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the healing arts act of this state, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such services are performed by an optometrist, dentist or podiatrist acting within the lawful scope of their license.

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> **40-2,101. No policies, contracts or agreements for medical service shall deny reimbursement or indemnification for any service within scope of practice licensed under Kansas healing arts act.** Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the Kansas healing arts act, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such service is rendered by any such licensed practitioner within the lawful scope of his license.

Several years later in 1997 the Legislature recognized that the evolution of managed care plans had compromised some of the established principles embodied in the laws governing health insurance. For that reason, the Legislature passed the Kansas Patient Protection Act (K.S.A. 40-4601 *et. seq.*).

More recently we are informed there are a couple of court cases pertaining to assignment of benefits that raise questions and perhaps create exceptions to the general public policy of this State. We acknowledge that legitimate, self-funded health plans subject to the federal Employee Retirement Income Security Act are exempt from state regulation by either the Legislature or the Insurance Commissioner. But this does not mean the Legislature should ignore the majority of the individual and group health insurance policies sold to Kansas consumers.

There are also practical reasons why the Legislature should reaffirm health insurance consumer protections. Nowadays there are so many different health plans and insurance products, a physician cannot possibly be expected to apply for provider participation status in every one of them. If a major employer in the physician's community purchases a group health insurance policy covering a significant number of local workers, the physician will normally submit the necessary documentation for credentialing, and enter into a provider participation contract with the insurer. But if there are conditions of participation that are objectionable, the physician should not be expected to accept an unreasonable fee schedule or sacrifice clinical autonomy. In that event, the patient should not be required to discontinue his or her established relationship with a trusted physician, particularly if the patient has a chronic condition or is undergoing a series of treatments over a period of time.

Ostensibly, most patients already enjoy the opportunity to obtain their health care services from a non-participating (out-of-network) provider. The patient simply must pay for his or her health care services and then submit to the health insurer a claim for reimbursement of their costs. If the reimbursement is less than the amount actually paid by the insured patient, the difference is the price paid for exercising his or her freedom of choice. Of course this creates a significant incentive to obtain health care services from a participating provider.

If the patient needs expensive health care services, particularly if the illness or injury requires hospitalization, the patient may not be able to afford the significant cost. This could create a hardship for the patient, or at least a major inconvenience, while they await reimbursement from their health insurance company. The ability to assign their health insurance benefits directly to the health care provider of their choice avoids this cash-flow problem.

Senate Bill 175 would reaffirm the fundamental principle of patient ownership of health insurance benefits, and would promote patient freedom of choice among health care professionals. For those reasons, we urge you to recommend passage of SB175.

Bert O. Oettmeier, Jr., DDS, PA

Madam Chair and Members of the Committee,

I regret that I can not attend today's hearing, but I would like to provide this written testimony in support of SB-175.

Kansas State Statutes 40-439 and 40-440 very clearly acknowledge and declare "the existing right of assignment of interests under individual group life and accident and health insurance policies."

Not allowing the citizens of Kansas to exercise their statutory rights is unfair to the people of this state. We Kansans put our trust in our elected officials to protect our rights and preserve our freedom of choice.

The argument by opponents that this bill would increase costs is completely unfounded. If passage of this bill affected costs at all it would lower them by allowing bulk payments to providers rather than individual payments to the insureds.

Those insureds that seek "in-network" care do so because it provides a cap on the fees charged. Offices which contact as "in-network" providers do so because they feel they must do so to provide a steady stream of patient seeking those capped fees. Assignment of benefits has absolutely nothing to do with why insureds choose providers or why providers participate.

Denying assignment of benefits is simply a "strong arm" tactic by third party payors to try to coerce non-participating offices to join their plans. Current "in-network" providers would not leave these plans if this bill passes because that is not why they are participating. I would ask you to speak to your constituents to confirm their desires to preserve those rights and freedoms under current state statues.

I urge your support and passage of SB-175.

Respectfully,

Bert W. Oettmeier Jr. DDS

Bert W. Oettmeier Jr., D.D.S.
Immediate Past President, Kansas Dental Association

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2-20-07
Attachment 8

BRAD SMOOT
ATTORNEY AT LAW

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SUITE 230
LEAWOOD, KANSAS 66206

Statement of Brad Smoot
Legislative Counsel
Blue Cross Blue Shield of Kansas
Blue Cross Blue Shield of Kansas City
Senate Financial Institutions & Insurance Committee
Regarding SB 175
February 20, 2007

Madame Chair and Members:

Blue Cross Blue Shield of Kansas is a mutual insurance company domiciled in Kansas and serving approximately 700,000 customers in 103 counties. Blue Cross Blue Shield of Kansas City is a nonprofit hospital/medical service corporation serving about 200,000 Kansans in Johnson and Wyandotte counties in Kansas and some thirty-five counties in Western Missouri. We are pleased to have an opportunity to comment on SB 175, a mandate that insurers honor assignment of benefits.

BCBSKS, BCBSKC and most other large insurers contract with Kansas providers, including hospitals, doctors, pharmacists, dentists, etc. We do so for one reason. Providers who contract with us agree to accept our reimbursement as full payment (except for co pays and deductibles, of course). That means we get to have some say in what health care services cost AND we require that providers not bill our customers for the difference between their charges and what we pay. Such billing is commonly referred to as "balance billing." It is easy to see why this practice helps control both the size of premiums and the out-of-pocket expenses of our customers; your constituents.

In 2006, BCBSKS saved our customers $790 million in what would have been balanced billed charges as a result of our contracts with health care providers. The ability to refuse to honor the assignment of benefits is one of the most significant reasons providers agree to our contractual terms. Absent this judicially recognized cost containment authority, providers would have little reason to agree to our "less than charges" payments and would be free to pursue our customers, your constituents, for the balance between charges and an insurer's reimbursement.

Various provider groups regularly ask the legislature to reverse this long standing practice. I first testified on this topic in 1993 (HB 2096) before the House Financial Institutions & Insurance Committee. That bill was tabled on a motion from then-Representative Sebelius. This Committee heard SB 457 in 2004 and an interim committee considered SB 166, reporting it adversely in 2005. After hearing both sides of the issue, no legislative committee has ever supported mandating assignment of benefits in accident and health policies.

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BCBSKS contracts with virtually all doctors and hospitals in Kansas. SB 175 is not a burning issue for those providers. More importantly, however, employers and employees are the beneficiaries of our contract negotiations and provisions limiting balance billing. They would be the big losers if SB 175 were to pass. Indeed, it is hard to imagine a proposal that is more anti-consumer than SB 175.

Thank you for consideration of our views.

Kansas Bankers Association

Date: February 13, 2006

To: Senate Financial Institutions & Insurance Committee

From: Doug Wareham, Senior Vice President – Government Relations

Re: Opposition to Senate Bill 175

Thank you Madam Chair and members of the committee for the opportunity to appear on this bill. After reviewing Senate Bill 175, we have some concerns that we would like to share as you consider this proposed legislation.

The Kansas Bankers Association has sponsored a health plan for its members for many years. The plan has been with Blue Cross Blue Shield of Kansas since 1948. We have been fortunate to have strong participation by our members for all of those years with close to 90% of our member banks participating in the plan.

As you are probably aware, health costs have risen to such levels that it is increasingly difficult for our members to provide insurance coverage to their employees. Hospital costs are one of the largest components of health care costs. There are limited tools to help in slowing the rate of increase in health care costs and an insurer's ability to refuse to honor assignment of benefits is one of them. We would not like to see this tool taken away, especially when health care costs already far exceed the rate of inflation.

Senate Bill 175 would require non-contracting providers to be paid directly by the insurance company. That would clearly erode the providers' incentive to contract with insurance companies. Thus, insurance companies wanting to maintain an adequate network of providers would be forced to increase their reimbursement to encourage participation, and that would result in even higher health insurance premiums for individual Kansans.

This proposed legislation appears to hurt the employees of our members. As mostly small employers, our banks will feel even more pressure to pass costs on to their employees.

Thank you for the opportunity to share these concerns.

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610 S.W. Corporate View 66615 | P.O. Box 4407, Topeka, KS 66604-0407 | 785-232-3444 | Fax 785-232-3484
kbaoffice@ksbankers.com | www.ksbankers.com

KSSmallBiz.com

ADVOCATES FOR KANSAS SMALL BUSINESS

P.O. BOX 1246 • TOPEKA, KS 66601-1246 • 785.232.4590. x205
www.KSSmallBiz.com

TESTIMONY
SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE
SENATE BILL 175

February 20, 2007
By Kenneth L. Daniel

Kenneth Daniel of Topeka is an unpaid volunteer lobbyist who advocates for Kansas small businesses. He is publisher of KsSmallBiz.com, a small business newsletter and website. He is C.E.O. of Midway Wholesale, a business he founded in 1970. Midway has seven Kansas locations and 110 employees.

MADAME CHAIRWOMAN AND MEMBERS OF THE COMMITTEE:

I am here to speak in opposition to Senate Bill 175.

Isolating the health care consumer from medical payment transactions is one of the primary reasons that health care costs are out of control.

Conversely, keeping them in the loop is a primary tenet of the consumer-directed health care movement, arguably the only solution to the health care costs crisis that is working at this time.

This bill will result in providers insisting on a bigger chunk of the consumer's dollar, but the consumer will be completely left out of that negotiation.

We need to be going the other way. We need to prevent insurance companies from paying providers as if the money is theirs and not the consumer's.

Health credit cards for most minor transactions would allow the provider to be paid in full immediately, but keep the consumer in the transaction.

Another unacceptable aspect of this is that it can force insurance companies to pay twice or more for the same transaction, simply because a complicated red tape procedure is not tracked. Worse yet, the cost of that red tape procedure and the double payments will run up health insurance costs with absolutely no benefit to the patient.

I strongly encourage you to oppose Senate Bill 175.

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2-20-07
Attachment 11

HEARTLAND COMMUNITY BANKERS ASSOCIATION

Matthew S. Goddard, Vice President

700 S. Kansas Ave., Suite 512
Topeka, Kansas 66603
Office (785) 232-8215 • Fax (785) 232-9320
mgoddard@hcbankers.com

To: Senate Financial Institutions and Insurance Committee

From: Matthew Goddard
Heartland Community Bankers Association

Date: February 20, 2007

Re: Senate Bill 175

The Heartland Community Bankers Association appreciates the opportunity to share our opposition to Senate Bill 175 with the Senate Committee on Financial Institutions and Insurance.

Through a subsidiary, HCBA markets a Blue Cross Blue Shield of Kansas group health plan to our membership. We have over 1,000 member employees currently enrolled, most of which are Kansans. Every year we struggle to keep premiums affordable and to minimize any premium increases. If we cannot keep premiums at a reasonable level, our members will be forced to pass more of the cost on to their employees, some of whom may choose to go without insurance.

One of our tools to combat rising health care costs is the cap system at Blue Cross. In order to be a part of the Blue Cross network of physicians or hospitals, a service provider must agree to accept a predetermined cost for various services and any charge above that amount is considered a "write-off." In our most recently concluded policy year, the cap system helped our group claims by writing off 38.5 percent of total billings, more than $4 million. Every provider in the Blue Cross network must participate in the cap program. Providers outside of the network are not subject to the cap program and can charge and collect whatever amounts they wish.

Insureds have an incentive to visit contracted service providers because, in addition to the cap program, they are subjected to a higher co-pay for leaving the network. The provider has an incentive to contract with Blue Cross and participate in the cap program because they are more attractive as a provider to Blue Cross policyholders. In addition, Blue Cross pays contracted providers directly but makes payment directly to insureds when they leave the network. Blue Cross does not allow for assignment of benefits, meaning insureds can't tell Blue Cross to pay their reimbursement directly to a noncontracting provider.

Senate Bill 175 would force Blue Cross to make payments directly to out-of-network providers. This would give these providers one of the major benefits of being a contracting provider without requiring their participation in the cap program. Providers could then choose to leave the Blue Cross network, charge fees well in excess of those allowed under the cap program and still enjoy direct reimbursement from Blue Cross. Such a scenario ultimately results in higher medical costs to Kansas consumers.

There is nothing wrong with a service provider making a business decision not to contract with Blue Cross Blue Shield. A provider has every right to charge the fees they consider appropriate and to avoid any programs that would restrict that right. A provider must understand, however, that an insurance company should also have the right to treat contracting providers differently from noncontracting providers. Senate Bill 175 infringes on that ability.

We appreciate your consideration of our opposition to Senate Bill 175.

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NFIB

The Voice of Small Business®

Legislative Testimony
Derrick Sontag, NFIB State Director
Senate Bill 175
February 20, 2007

Madam Chair and members of the committee:

Thank you for the opportunity to provide written testimony in opposition to Senate Bill 175.

Senate Bill 175, if enacted would remove the authority for insurance companies to refuse to make direct reimbursement to non-contracting providers. As a result, the bill seriously jeopardizes leveraging power in negotiating health care costs with providers.

The ability of insurers to refuse making direct reimbursements to non-contract providers is helpful to employers, in that it saves them money. The cost savings arises as a result of employers not being billed for the balance between their charges and the insurer's payment. This helps to keep premiums more affordable and reduces the out-of-pocket expense to our members.

Enactment of Senate Bill 175, ultimately would lead to higher health care costs by eliminating one of the few tools that insurers have to control health care costs.

The end result would be an anti-consumer piece of legislation that adds to the already excessive cost of employer's providing health care.

Thank you for your time and consideration on this important matter.

Derrick Sontag
Kansas State Director
National Federation of Independent Business
785-213-9769
Derrick.sontag@nfib.org

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Legislative Testimony

SB 175

February 20, 2007

Testimony before the Kansas Senate Financial Institutions and Insurance
By Marlee Carpenter, Vice President of Government Affairs

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 Teichman and members of the committee,

I am here today on behalf of The Kansas Chamber and our over 10,000 members to express concerns with SB 175, the expanded access to healthcare act. The passage of this bill would remove the authority for insurance companies to refuse to make direct reimbursement to non-contracting hospitals, doctors, and other providers. The Kansas Chamber of Commerce opposes the passage of this bill.

Direct reimbursement is a huge incentive for providers to contract with an insurance company. In exchange for direct payment, providers agree to accept a reimbursement rate and agree not to bill the customers for the balance between their charges and the insurer's payment. This helps lower the insured portion of the payment, helping to hold down premiums, and reduces the out-of-pocket expense of the insured persons.

The general rule is that assignments of benefits are to be honored by insurers, but Kansas has generally recognized an exception for the purpose of cost containment. The Kansas Supreme Court and the federal courts have all acknowledged health care cost containment as an important public policy. Under the federal ERISA law, self insurers will not be subject to SB 175 and would be free to continue refusing assignments. This would allow the state's self insured plan, "Kansas Choice," to reject assignments in order to protect your state workers from "balance billing."

An insurer should be able to prevent balance billing and negotiate good rates. They should be able to control premium increases and reduce out of pocket expenses to their customers. With the health care cost explosion and premiums already at levels that add to an already excessive uninsured rate, the passage of this bill would take away one of the few tools insurers have to help control costs. SB 175 would actually raise health care costs and is very anti-consumer. Several bills similar to this one have been rejected by the legislature over the last 15 years and I urge the committee to do the same with SB 175.

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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.

)03 E 104TH STREET 5TH FLOOR · KANSAS CITY, MO 64131 · WWW.HCAMIDWE :OM

February 19, 2007

HCA
Midwest Division

Senator Ruth Teichman
Chairperson
Senate Financial Institutions & Insurance Committee
300 S.W. 10th, Room 241-E
Topeka, KS 66612-1504

Re: Senate Bill 175

Dear Sen. Teichman:

It has come to my attention that the Committee on Financial Institutions and Insurance is conducting hearings regarding Senate Bill 175, regarding the assignment of payment of insurance benefits. From the perspective of a large hospital system, I wanted to make you aware that the practice of insurers prohibiting the assigning of benefits to a non-contracted healthcare provider is common in the health insurance industry, including in the State of Kansas.

When a patient receives non-emergency services from a non-participating provider, most health insurance companies in Wichita, Iola and Kansas City (i.e., those Kansas markets with which we are familiar and in which we operate healthcare facilities) routinely reimburse their insureds the covered amount, and then expect those insureds to reimburse the out-of-network provider directly.

I have personally worked in the managed care industry for over twenty years (on both the insurer and provider sides of the table), and can assure you that such non-assignability continues to be a common industry practice. As you well know, the practice increases the opportunity for competition and negotiation among health insurers and healthcare providers, which in turn helps to moderate health insurance costs.

While we understand that the non-assignment of benefits issue may be a concern to some providers, we and most other providers have learned to live within its parameters so that society will benefit from the enhanced competition that it fuels and its subsequent constraining effect on healthcare costs.

The current practice also ensures that patients are motivated to remain engaged in the financing and delivery of their healthcare, and acts as additional protection against potential abuses that – if left unchecked – would undoubtedly lead to even higher costs for the State's employers, their employees and their families.

Accordingly, the HCA-affiliated healthcare facilities that operate in the State of Kansas (Allen County Hospital, Menorah Medical Center, Mid-America Surgery Institute, Overland Park Regional Medical Center, Overland Park Surgery Center, Surgicare of Wichita, Surgicenter of Johnson County and Wesley Medical Center) respectfully request that SB-175 not be passed.

Thank you for your time and consideration. If I can provide further information, please do not hesitate to contact me directly at (816) 508-4060.

Sincerely,

Patrick L. Patterson
Vice President, Managed Care
CO-OK-KS-MO Region

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Attachment 15

DELTA DENTAL

www.deltadentalks.com

February 19, 2007

The Honorable Ruth Teichman, Chair, and Members
Special Committee on Financial Institutions and Insurance
State Capitol
Topeka, KS 66612

Re: Opposition to Senate Bill 175

Dear Senator Teichman and Committee Members:

I am the Vice President of Sales and Marketing for Delta Dental of Kansas. I am writing to share you with you Delta Dental of Kansas' opposition to Senate Bill 175. Delta Dental of Kansas is the largest dental benefits carrier in the state of Kansas. We sell benefits plans to companies with headquarters in Kansas and currently serve about 780,000 enrollees. Some of our customers include Sprint, Yellow Roadway, the State of Kansas, Westar, Raytheon, Payless Shoe Source and the employees of Spirit Aerosystems (formerly Boeing.)

All of the customers I just mentioned – including the State of Kansas – will face higher costs for dental benefits if SB 175 is passed. Let me explain the implications if this legislation is enacted. Specifically, here's what will happen.

First, there will be higher costs for employers – We pay our participating dentists a higher level of reimbursement than what we pay non-participating dentists. If we're forced to reimburse non-participating providers at the same level as participating providers, our claims costs naturally increase, and this will mean higher costs for the dental benefit programs we sell.

Second, patients will pay higher costs – When a Delta Dental enrollee visits a participating dentist, that dentist agrees to a set reimbursement from us, and cannot charge the patient for any costs above that agreed upon reimbursement rate. But, non-participating dentists require their patients to pay the full cost of services provided. Their patients aren't protected against fees charged that are higher than what the benefits plan allows. As the number of non-participating dentists increases, so will the overall cost of care for patients.

We'll see lower participation in networks - Direct provider reimbursement is an incentive for dentists to join our network and to accept participation requirements – including accepting allowed fees with no balance billing. Without it, a significant reason to participate will be lost, so fewer dentists will join a dental network. And without networks, we lose a big part of our competitive advantage.

Higher administrative costs – By not allowing assignment of benefits, we're able to reduce administrative costs, and that helps keep our rates low. Distribution of payment based on assignment is more administratively complex, so it will require additional systems costs. Those costs will ultimately be passed to our customers and enrollees.

It seems that every day we hear how the prices for healthcare are going up. And we know that Governor Sebelius, the Healthcare Policy Authority, and all of you are searching for ways to provide affordable healthcare, including dental care, for all Kansans. We believe the passage of this legislation would jeopardize your efforts to do this.

I appreciate your consideration of my perspective as the Committee studies this proposed legislation. Should you have any questions, please feel free to call me at (913) 381-4928.

Sincerely,
Dean Newton
Vice President, Sales and Marketing
Delta Dental of Kansas

DELTA DENTAL OF KANSAS	Main Telephone	316-264-1099	800-722-5823	Fax: 316-462-3393
1619 N Waterfront Parkway	Customer Service	316-264-4511	800-234-3375	Fax: 316-462-3392
P.O. Box 789769	Marketing & Sales	316-462-8413	800-264-9462	Fax: 316-462-3329
Wichita, KS 67278-9769	Eligibility & Enrollment	316-264-4511	800-234-3375	Fax: 316-462-3394

FII
2-20-07
Attachment 16

Kansas Association
of Health Plans

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

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Fax 785-233-3518
kahp@kansasstatehouse.com

Statement of Larrie Ann Lower
Executive Director
Kansas Association of Health Plans

Committee on Financial Institutions and Insurance

2007 Senate Bill 175
February 20, 2007

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

The KAHP is a nonprofit association dedicated to providing 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 Kansans covered by private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and medicaid managed care. We appreciate the opportunity to provide written comment on SB 175.

The KAHP appears here today to explain our opposition to SB 175 prohibiting health insurance companies from utilizing non-assignment of benefits clauses. Health plans establish a "network" of providers that agree to terms negotiated between the provider and the health plan. Among the terms in-network providers agree to are negotiated reimbursement rates and not to balance bill a patient for the difference between the negotiated rate and actual charge.

Health plans utilize various mechanisms to encourage providers to participate in a network. One of those mechanisms plans can use is to refuse to pay non-contracting providers directly. Providers commonly require customers to sign an assignment of benefits form. This assignment of benefits language says that the patient is allowing their benefits (reimbursement for medical costs paid by the health insurance company) to be paid directly to the provider regardless of whether the provider is participating in a network established by the health plan. However, our customer's insurance contract often contains a clause exercising a right of refusal to honor the customers assignment to an out of network provider (non assignment clause). SB 175 would prohibit such clauses, therefore requiring health plans to pay out of network providers directly.

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Attachment #7

SB 175 applies to all providers and would prohibit this mechanism health plans can utilize to encourage providers to contract with them which helps control the ever increasing cost of health care. Under federal rulings, Kansas cannot prohibit non-assignment clauses in health insurance contracts that are part of an ERISA self-insured plan. Furthermore, Kansas courts have recognized the use of non-assignment clauses in certain instances since 1981. The most current Kansas case addressing non-assignment clauses allows the use of the clauses if they are part of a cost containment strategy.

Not only has this issue been the subject of Kansas court proceedings, but as others will explain, this issue has been debated several times by the legislature. In 1993, a fiscal note was prepared for a similar bill, but would have only applied to BCBS-KS and was only analyzing the potential impact on the state employees health plan and local units of government. The Division of Budget estimated the legislation would have impacted the state's 1995 general fund by approximately $8.6 million and all funds, state and municipal, by $18 million. The estimated impact for cities, counties and school districts was an increase in premiums by as much as 19.4%. The fiscal note states: "The long range effect of this bill would be that the state as well as individual employees would most likely have to pay higher premiums for health coverage. The inability to implement managed care programs could cause the state's health care costs to increase more rapidly than they already are. The number of physicians and hospitals willing to participate in managed care networks could decrease since insurance providers would have no leverage to either encourage or discourage them." The impact would be especially felt in smaller communities where the absence of managed care networks would allow these providers to charge fees higher than allowable maximums. Obviously, the impact of SB 175, a much broader bill, could be far more costly to the taxpayers.

Thank you for your thoughtful consideration of this issue.