Approved: February 22, 1993
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson William Bryant at 3:30 p.m. on February 15, 1993 in Room 527-S of the Capitol.

All members were present except:

Committee staff present: William Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:
Bill Henry, St. Francis Regional Medical Center
James R. Petrich, Willis Corroon Corp. of Kansas
LeRoy Rheault, CEO, St. Joseph Medical Center
Tom Bell, Kansas Hospital Association
Brad Smoot, Blue Cross/Blue Shield
Thomas L. Miller, Blue Cross/Blue Shield
Collier W. Case, Western Resources
Dave Charay, Kansas Employees Health Commission
Jim Mayer, Kansas Association of Realtors
Jim Biltz, HCA Wesley Medical Center
Joe D. Pucci, Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas
Trudy Aron, American Institute of Architects
Jim Schwartz, Kansas Employers Coalition on Health
Rich Hunker, Insurance Department

Hearing on HB 2096: Accident and health insurance payment of benefits

Bill Henry, representing St. Francis Regional Medical Center, stated that the bill would repeal the authority of Blue Cross/Blue Shield to utilize a procedure called non-assignment in payment to health care providers. BC/BS now has the authority to request and accept bids from hospitals for contracting for discounts. St. Francis participated in this arrangement until last year when it determined that cost-shifting to other patients was not feasible due to its particular hospital population and chose not to renew a bid but thought it was operating under a previous contract which is not current now. Since St. Francis is no longer a contracting health care provider, any BC/BS insured who receives treatment at St. Francis receives a reduced check from Blue Cross/Blue Shield. St. Francis must then seek payment from that individual which can be difficult. This practice was intended to be a cost-containment measure but has developed into a competitive lever to persuade hospitals to contract with BC/BS. It becomes the responsibility of the insured to determine if his insurer has paid the correct amount under the policy terms. Allowing non-assignment leaves the patient with no counsel to aid him in seeing that he is paid correctly; he has no ally (Attachment 1).

Dr. Douglas Stratton, Vice President/Executive Director of CIGNA Health Plan of Kansas/Missouri, Inc., presented written testimony to the Committee (Attachment 2).

James R. Petrich, Vice President of Group Operations for Willis Corroon Corporation of Kansas (WCCK), appeared as a proponent of the bill for the following reasons (Attachment 3):

1. If all group health insurance carriers were allowed to accept assignment of benefits only for health care providers with whom they contract, and pay benefits directly to the patient when non-contracting providers were involved, all consumers would suffer the cost of higher administrative costs and further providers cost-shifting.

2. When patients are paid directly, in many cases they do not pay their health care bills or partially pay their bill and setup periodic payment schedules for the balance. This increases administrative costs for the provider, may increase bad debt for consumer, and ultimately increase fee schedules for all consumers.

3. The above mentioned additional costs works in opposition to the federal government and insurance industry's efforts to reduce costs.

4. Unfair to allow Blue Cross/Blue Shield to operate outside state requirements regarding assignment of benefits.

5. All carriers should have the ability to accept assignment of benefits only for health care providers with whom they contract or they all should honor provider assignment benefits.

6. Blue Cross/Blue Shield has taken the position that if providers do not contract with them they will force additional administrative costs on those providers. This is punitive, petty, and malicious.

7. Blue Cross/Blue Shield wants to punitively use their "special" assignment of benefits provisions as a weapon against providers who choose to contract with other commercial carriers (in lieu of BC/BS).

8. Blue Cross/Blue Shield is not thinking of cost containment but rather of punishment for those who dare to compete against them.

LeRoy Rheault, President and CEO at St. Joseph Medical Center, stated that the technical amendment passed last session as SB66 which gave BC/BS the statutory authority to refuse to accept assignment of benefits to the health providers who are not contracting with them should be repealed (Attachment 4). It infringes on the individual's right to transfer the benefits of his health insurance to a provider other than Blue Cross and, accordingly, interrupts the free flow of normal business transactions. It clearly gives Blue Cross a competitive advantage over other mutual companies and does not accomplish the purposes most frequently touted by Blue Cross as reasons justifying the position for allowing non-assignability of contract rights: access, cost containment, and cost shifting.

Tom Bell, Kansas Hospital Association, stated that their support of the bill was based on the potential negative effect of the current law on hospital patients and its equally negative potential for health care providers (Attachment 5).

Brad Smoot, Legislative Counsel of Blue Cross/Blue Shield of Kansas, appeared in opposition to the bill (Attachment 6). Mr. Smoot gave a history of legislation regarding BC/BS becoming a mutual company and past contractual and billing practices. Advantages of contracting is that BC/BS can negotiate a reimbursement rate that is less than is otherwise charged. Also providers do not bill the patient for any excess above the agreed contract price known as "balance billing." BC/BS sought bids for hospital service in the highly competitive Wichita market and only HCA Wesley responded with a bid. St. Franicis Hospital has launched a campaign for the proposed legislation after the hospital's suit was rejected in Federal District Court.

Tom Miller, CEO and President of Blue Cross/Blue Shield of Kansas, explained the reasons BC/BS had intended to select two out of the three largest Wichita hospitals as contracting hospitals even though only Wesley Medical Center was the only respondent (Attachment 7). They had been told by the hospitals that the only way to get a better price was to bring in a greater volume of patients to the hospital. In an attempt to obtain discounts in order to hold down a probable rate increase that would have been passed on to insureds, they accepted the Wesley bid which will result in a savings of well over 9% in Sedgwick County and in a savings of more than $13 million statewide. This is possible through the anti-assignment provision which this proposed legislation would prohibit.

Collier W. Case, Manager of Employee Benefits for Western Resources, stated that the bill would not encourage self-insuring companies to set up contractual arrangements and allow direct payment only to contracting health care providers in an effort to control costs (Attachment 8). There would be no incentive to reduce prices or vary service if non-contracting competitors were receiving the same benefit with none of the sacrifices.

Dave Charay, Benefits Administrator of the Kansas State Employees Health Care Commission, stated that the passage of this bill wold destroy the effectiveness of health insurance providers to control hospital and physician cost by taking their ability away to apply incentives or disincentives for providers to participate or unattractive for them not to participate (Attachment 9). It would be difficult for Health Benefits Administration to negotiate health insurance contracts with health insurance providers that could have effective managed care arrangements as there would be no leverage to apply incentives or disincentives for physicians and hospitals to participate in their network. The long range effect of this bill would be that the State of Kansas as well as state employees would most likely be paying higher premiums for health coverage.

Jim Mayer, Executive Vice President of the Kansas Association of Realtors, stated opposition to the bill for the following reasons (Attachment 10):

1. BC/BS's ability to negotiate the costs of health care with providers has helped in the curtailment of health care costs.

2. The current practice eliminates provider balance billing.

3. BC/BS handles paperwork for insured.

4. No major increase in premiums due to administrative and rising costs.

Jim Biltz, President and CEO, HCA Wesley Medical Center of Wichita, stated they had complied with BC/BS's request for bids and were very satisfied with the arrangement (Attachment 11). Other hospitals had the same option but declined to participate. Their discount and savings to BC/BS patients are dependent upon the retention of the assignment provision.

Joe D. Pucci, Administrator of the Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas, spoke on behalf of their 2,500 participants (Attachment 12). Even though the Fund is a self-funded insurance plan, the current legislative language is very beneficial to its members because a contracting hospital agrees to accept the allowable payment as payment in full for their membership. The hospital cannot bill the members for charges in excess of what they have agreed to pay, thus eliminating credit risk for the hospitals. BC/BS performs the administrative services for their Group and they utilize the BC/BS Network of Providers.

Trudy Aron, Executive Director of the American Institute of Architects in Kansas, opposed the passage of the bill because it would allow hospitals and other health care providers to escalate their prices without establishing cost cutting measures (Attachment 13).

Jim Schwartz, Consulting Director for the Kansas Employer Coalition on Health, voiced opposition to the passage of the bill because managed care appears to be the approach this country is taking to deal with soaring health care costs (Attachment 14). Contracts must be allowed to exercise their incentives and if they don't work, the market will reflect the failure, but it should not be legislated.

Rich Huniker, Insurance Department, presented the Committee with copies of a memo from Ron Todd, Insurance Commissioner to the head of the conference committee on SB 66, dated April 7, 1966, stating the position of the Insurance Department and an explanation of the proposed legislation (Attachment 15).

A fiscal note for HB 2096 was distributed (Attachment 16).

During discussion, the Committee requested the three major hospitals in Wichita to provide market share information to determine if the main problem is too many beds for the population base. Most self-funded and ERISA plans will continue with their current programs and not fall under the proposed legislation.

Representative Correll moved for the approval of the February 11, 1993 minutes. Representative Allen seconded the motion. The motion carried.

The meeting was adjourned at 5:00 p.m. The next meeting is scheduled for February 16, 1993.

GUEST LIST

COMMITTEE: H. L. & L. DATE: Feb. 15

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIO
BILL HENRY	TOPEKA	St. Francis
Jim Lumry	Topeka	Western Resources
Collier Case	Topeka	Western Resources
Jim Schwartz	Topeka	KECH
DAVE CHARAY	Topeka	HCC
BRUCE CARMICHAEL	WICHITA	St Francis Rad. Med Ctr
Tom Bell	Topeka	ICHA
Jerry SLAUGHTER	Topeka	KMS
BEN NEILL	Overland Park	St. Francis Med. Ctr
Stan Henderson	Wichita	St. Francis Regional
Bill SNEED	TOPEKA	KHA
Rick Liby	Topeka	Gehrt & Roberts
Rick HUNTER	Topeka	KS DOT
Jim MAKER	TOPEKA	KS Assoc of Realtors
Jim McHoff	Topeka	KS AFL-CIO
Joe Fucci	Wichita	Pipefitters Local
LeRoy Rhemert	Wichita	St. Joseph Medical Center
Fred Palenske	Topeka	BCBS of KS
Kathy Sexton	"	DOB
Jim Petrich	Wichita	Willis Corroon

TESTIMONY
Monday, February 15, 1993
House Financial Institutions & Insurance Committee

Chairman Bryant, members of the Committee, I am Bill Henry and I appear before you today on behalf of St. Francis Regional Medical Center of Wichita, Kansas in support of H.B. 2096.

H.B. 2096 repeals the authority of Blue Cross-Blue Shield to utilize a procedure called non-assignment in payment to health care providers.

Beneath the guise of a technical amendment this non-assignment authority was given to Blue Cross-Blue Shield in a conference committee on S.B. 66 last year. What is non-assignment and why does it hurt health care providers in our state? Under Kansas law there is a preference for assignment. That is, an insured who receives benefits from health care providers through assignment authorizes his insurance company to pay the health care provider directly. Years ago when Blue Cross-Blue Shield was closely regulated by the State Department of Insurance it was granted this authority in exchange for carrying out cost containment measures in dealing with the providers with whom they had contracted.

After the passage of S.B. 66 last year Blue Cross-Blue Shield <u>is the only mutual insurance company</u> with such power in the State of Kansas.

The issue of non-assignment of health insurance is a major question of policy that should be determined by this Committee. Indeed, in Federal Court last year, counsel for Blue Cross-Blue Shield told the court that this is an issue that should be determined by the Legislature.

First, what has happened in Wichita? A few days after Governor Finney signed S.B. 66 into law Blue Cross-Blue Shield announced in a request for proposals (RFP) that it wanted new low bids for performing services for Blue Cross-Blue Shield insured. At that time, all Wichita hospitals were contracting hospitals with Blue Cross-Blue Shield. Each hospital in compliance with this contract of Blue Cross-Blue Shield worked in conjunction with the company in cost containment. St. Francis Regional Medical Center has been a contracting hospital with Blue Cross-Blue Shield since 1980. This time, however, Blue Cross-Blue Shield said it would only issue contracts after competitive bids with two of the hospitals in Wichita. In its request for a proposal, Blue Cross-Blue Shield also said that it wanted greater discounts than were currently in place.

St. Francis Regional Medical Center, after a great deal of discussion, determined it could not submit a lower bid or provide lower discounts because the facility could not shift its costs to other patients in the hospital because of the particular make up of

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its hospital population. Secondly, St. Francis felt it had a contract with Blue Cross-Blue Shield that was already in place. Finally, St. Francis Regional Medical Center was never offered a contract to continue its services with Blue Cross-Blue Shield.

After receiving further communications with Blue Cross-Blue Shield, St. Francis Regional Medical Center sought a temporary injunction in Federal District Court but Judge Kelley refused that request for injunction.

That brings St. Francis Regional Medical Center before you today. Since St. Francis is no longer a contracting health care provider any Blue Cross-Blue Shield insured who receives treatment at St. Francis receives a reduced check from Blue Cross-Blue Shield. St. Francis Regional Medical Center must then seek payment from that individual which is a difficult business.

For example, St. Francis has the only burn center in the state of Kansas. If a patient has to undergo treatment at the burn center, those costs are very expensive. Instead of St. Francis receiving the check, for those treatments, the reimbursement amount would be mailed directly by Blue Cross-Blue Shield to the patient. Getting collection on that amount of expense from an individual who has been treated in your facility can be a difficult task.

One of the comments that I am sure you will hear today is that the use of this non-assignment power by Blue Cross-Blue Shield is that it is cost containment. That is not true.

Last December several Blue Cross-Blue Shield employees had their depositions taken. In those sworn depositions the same employees explained that the use of non-assignment was a competition tool that should be utilized in getting hospitals to contract with Blue Cross-Blue Shield where true cost containment policies could then be implemented.

The use of a non-assignment policy by Blue Cross-Blue Shield is not a cost containment device in and of itself. It is a competitive lever that can be brandished about in the market place to convince the hospital to contract with Blue Cross-Blue Shield. In the past, that is exactly how this lever has been utilized.

But this unique tool, given solely to Blue Cross-Blue Shield, has now been turned into a punitive weapon. The reason is Blue Cross-Blue Shield no longer wants St. Francis Regional Medical Center as a contracting partner. Indeed, Mr. Chairman, members of the Committee, the only cost containment that is taking place today with the use of this non-assignment tool, is to contain the cost of Blue Cross-Blue Shield and to shift those costs to other members of the hospital population in Wichita.

H.B. 2096 will not give St. Francis Regional Medical Center any more funding from Blue Cross-Blue Shield.

More important to this Committee than the financial security of St. Francis Regional Medical Center, however, is this fact.When payment is sent directly to a patient by an insurer that patient is left to his own resources to determine if his insurer has paid the correct amount under his policy terms. Sure, the patient, by studying the billing can perhaps guess why the insurer has paid the particular amount in question. The patient, indeed, may call his insurer and ask why procedure 233 was not paid for by the insurer. The fact is, only a hospital and only the insurance company have the expertise necessary to interpret billings and payments.

So, when this Committee allows non-assignment you leave the insured without his last shield. You leave the patient with no counsel to aid him in seeing that he is paid correctly. Generally speaking, there are normal disputes over billing. Because the hospital wants to see the patient is paid, the hospital will go to bat for the patient in disputes over billing with the insurer. Because both the patient and the hospital have so much to gain in this situation, their interests are mutual and because the hospital has more expertise and understanding then a semi-level playing field exists. The hospital and the patient are on one side and the insurer is on the other side. However, when direct payment is made to the patient, a major player in this balanced field is removed from the table. What is left then, is the patient and the insurer. That is not a good situation for the insured.

If you allow this non-assignment authority to be continued by Blue Cross-Blue Shield, you leave the patient without an ally. You leave the patient without the expertise of a hospital that knows the limits of insurance policies, knows the particular situation and the why of why a given procedure was utilized. For that reason, and that reason alone, this Committee should report H.B. 2096 favorable for passage.

CIGNA Healthplan of Kansas/Missouri, Inc.

2959 N. Rock Road
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(316) 636-1152

February 15, 1993

Kansas Legislature
Committee on Financial Institutions
and Insurance

RE: House Bill 2096

Dear Committee:

CIGNA appreciates the opportunity to provide its opinion concerning the recently introduced House Bill 2096 which, in part, would repeal Senate Bill 66. In particular, Senate Bill 66 would be modified to excise that portion that would allow Blue Cross the right to disallow assignment of subscriber benefits to healthcare providers who do not contract with Blue Cross.

There are two bases upon which we would support the partial repeal of Senate Bill 66. First of all, the underlying premise that supports the original assumptions for allowing a carrier to selectively exercise the assignment of benefits is not sufficient to warrant the detrimental impact caused to the insured and the public in general. The original enactment was partially premised on the cost containment that the assignment of benefits can contain. And while it is true that there is "cost containment" impact that results in contracting leverage with would-be providers, once those agreements are signed the benefit of cost containment in large measure ends. What then results is significant potential problems to the insured and the public.

The insured faces potential problems when payments are made directly to them rather than the provider. This frequently results in the insured using the funds for other purposes and ultimately being unable or unwilling to adequately reimburse the provider. The provider often has no recourse but to seek reimbursement through aggressive collection efforts or litigation. Either case causes a undesirable result.

In turn the public is harmed by the economic impact of cost shifting that occurs when the providers can't recover for their services from a portion of their patients.

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It is a step backwards to allow insurers to use an assignment of the benefit as a "cost containment" tool when the outcome results in providers and the insured having to become adversarial and the general public being penalized because of cost shifting.

The second basis, and of similarly grave concern to CIGNA, is the action taken by the legislature that would allow one carrier specific legislative authority without regard to the impact on the other insurers that operate within this state. Such action smacks of preferential treatment and unfair advantage. During the period that Blue Cross was treated as a separate legislative enactment and regulated as a unique entity, it is understandable that it would require special enactments to assure its compliance with the legislative directives. However, Blue Cross has chosen to withdraw from that status and should no longer be entitled to special legislative enactments.

I regret that I am unable to attend the Committee Hearings scheduled for February 15, however we sincerely appreciate the opportunity to voice our concerns.

Yours truly,

D. Douglas Stratton
Vice President/
Executive Director

DDS/gm

WILLIS CORROON

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February 15, 1993

The Honorable Bill Bryant & House Committee Members
Financial Institutions & Insurance
State Capitol
Topeka, KS 66612

RE: House Bill 2096

Dear Sirs:

My name is James R. Petrich and I am Vice President of Group Operations for Willis Corroon Corporation of Kansas (WCCK). WCCK is a licensed Kansas Third Party Administrator which actually pays claims on behalf of nine different commercial group health insurance carriers and represent (sells for more than twenty-five other insurance carriers. We are strongly in favor of the House Bill 2096 for the following reasons:

1. For years commercial health insurance carriers have been required to honor assignment of benefits in order to steam-line administrative functions for both providers and insurance companies, facilitate claims processing and make it more convenient for consumers. All parties know the money is owed to the provider and the consumer has actually told the carrier to pay the provider by signing the assignment form. Why not make it less cumbersome and less expensive by honoring the assignment of benefits? If all group health insurance carriers were allowed to accept assignment of benefits only for health care providers with whom they contract, and pay benefits directly to the patient when non-contracting providers were involved, all consumers would suffer the cost of higher administrative costs and further provider cost-shifting.

2. When patients are paid directly, in may cases they do not pay their health care bills (they use the money for other purposes) or partially pay their bill and set-up periodic payment schedules for the balance. This increases the cost of the providers' billing and collection functions, increases their bad debt and requires additional legal services. These costs are all passed on to consumers in the form of higher provider fee schedules (in order to account for the additional costs associated with the above).

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3. The additional administrative costs, not to mention the corresponding chaos and confusion created on the part of the consumer, flies in the face of everything the Government is trying to accomplish on the Federal Level. The Federal Government and Insurance Industry are trying to significantly cut down on excess administrative paperwork and utilize uniform practices in order to reduce overall health care administrative costs.

4. Blue Cross and Blue Shield of Kansas (BC/BS) recently requested to change their corporate structure in order to be treated the same as commercial health insurance carriers. Once approved, however, they then wanted to be treated more favorably then commercial health insurance carriers (i.e. they did not want to abide by the State's requirement on commercial carriers to honor provider assignment of benefits). This is wrong and the Legislature should have never allowed one health insurance carrier to be treated more favorably than the others, with respect to this area (i.e. it's like saying it is OK for one insurance carrier to shift additional provider administrative costs on to consumers as long as other health carriers aren't allowed to do it).

5. All commercial carriers and BC/BS should be treated alike. They all should have the ability to accept assignment of benefits only for health care providers with whom they contract or they all should honor provider assignment of benefits. As mention earlier, the insurance carriers we represent feel it is better to streamline administrative functions and reduce unnecessary costs than to increase administrative costs and require providers to further cost shift to consumers in the form of higher fee schedules. Honoring provider assignment of benefits is consistent with the uniform standards supported at the Federal Level.

6. What I find ironic is that the assignment of benefits provisions do not contain costs at all. Effective Managed Care is accomplished by well thought-out Plan Design, cost-effective provider contracting, good communication skills, good relationship building between the providers, insurance carriers & consumers and Trust. For BC/BS to take the position that if providers don't contract with them, they will force additional administrative costs on those providers and unnecessarily burden the consumers who choose to utilize their services is not only punitive, but petty, malicious and much beneath them. These distasteful elements have no place in health care reform discussions.

7. Commercial health insurance carriers have effectively implemented Managed Care Arrangements for years while honoring assignment of benefits provisions to hold down administrative costs and facilitate claims processing. This is nothing new. BC/BS wants to punitively use their "special" assignment of benefits provisions as a weapon against providers who choose to contract with other commercial carriers (in lieu of BC/BS). It would be wrong for the Kansas Legislature to allow this to happen without first considering the impact on costs if all carriers were allowed to do the same.

8. Large Self-Funded Employers around the country could avoid State assignment of benefits laws, but choose not to in order to better facilitate their claims process, hold down administrative costs and make it more convenient for their employees. In my opinion BC/BS is not thinking of cost containment at all with their actions, but rather thinking of punishment for those who dare to compete against them. We must break down these barriers to cost effective health care if we are going to make meaningful progress in delivering health care in its most cost efficient form.

In summary, we support House Bill 2096. The Kansas Legislature should assure that all group health insurance carriers (including BC/BS) are treated equally and fairly and that all parties reduce unnecessary administrative costs whenever possible. This is not only the right position to take, but supports national and other state efforts of more administrative uniformity to hold down overall health care costs.

Respectfully submitted,

WILLIS CORROON CORPORATION OF KANSAS

James R. Petrich, FLMI
Vice President of Group Operations

JRP/ghp

Committee on Financial Institutions and Insurance:

Dear Members of the Committee:

My name is LeRoy Rheault. I am the President and Chief Executive Officer at St. Joseph Medical Center. I am appearing before you today in support of passage of HB 2096. This bill would repeal a technical amendment passed last session as SB 66. This legislation gave Blue Cross the statutory authority to refuse to accept assignment of benefits to the health providers who are not contracting providers with Blue Cross.

At the present time this particular provision directly impacts St. Joseph Medical Center as we do not have a contract with Blue Cross.

We believe the question of non assignability of contract rights is ill advised from many points of view.

First, it infringes on the individual's right to transfer the benefits of his health insurance to a provider other than Blue Cross, and accordingly interrupts the free flow of normal business transactions. It clearly is burdensome and problematic to patients, confusing further an already complicated process for processing healthcare claims and increasing the existing paperwork.

It clearly gives Blue Cross a competive advantage over other mutual companies (keep in mind it is the only company that has been given this authority) and it does not accomplish the purposes most frequently touted by Blue Cross as reasons justifying the position for allowing non assignability of contract rights.

I would now like to elaborate on three issues in more detail. They are access, cost containment, and cost shifting.

1. Access: A point often raised by Blue Cross is one of access. St. Joseph Medical Center does not discriminate on the ability to pay or not pay. The same access is available to all. The ability of a patient to assign or not assign benefits has nothing to do with access.

2. Perhaps the most frequently discussed point is one of cost containment. This argument is not a valid one. The real cost containment comes from the PPO contract when sufficient discounts are given as a result of competive bidding. The decisions of what to bid, what to accept as bids, and what savings, if any, are passed on to consumers are not at all tied to the assignment. The intent of the bid process in Wichita was to select only two providers out of the three major providers. The unsuccessful bidder would not be able to accept assignment. This creates a problem for both patient and hospital. Cost containment is not achieved by non assignability, but is achieved through a successfully negotiated contract.

3. Cost shifting: It should be noted by the Committee that this issue of non assignability was with us some years ago when a number of Kansas hospitals failed to come to terms with Blue Cross in the contract negotiations in 1981. In the short period of time that contract assignments were refused, the non contracting hospitals saw payments given to the patient who in turn

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cashed checks many times and failed to pay the hospital. This drove up accounts receivable of the hospital, impacted cash flow, and resulted in more expense to the hospital in causing the cost of collection to increase. This increased cost is ultimately a form of cost shifting, increasing the cost to the hospital and ultimately to all payors.

I would also like to point out that it is interesting that the provision for assignment was quietly slipped into SB 66, at a time when Blue Cross was becoming a mutual company and giving this company provision that no other insurance company could utilize.

In summary, I believe this is not a cost containment or access issue, that it is burdensome to the hospital and to the patient, increases accounts receivable, and causes cost shifting. I believe that it greatly burdens the public as well as the hospitals.

Thanks for giving me the opportunity to present my comments. I encourage you to support HB 2096.

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

February 12, 1993

TO: House Committee on Financial Institutions and Insurance

FROM: Kansas Hospital Association Tom Bell

RE: **HB 2096**

The Kansas Hospital Association appreciates the opportunity to present testimony in support of HB 2096. This bill would repeal language adopted by the Legislature last session allowing Blue Cross and Blue Shield of Kansas to prohibit a patient from assigning his or her benefits to the treating health care provider. We would like to make several brief points.

First, we think it is important for this issue to be fully and openly debated by the Legislature. We don't think that lawmakers had an adequate opportunity to thoroughly consider this important public policy question last session. The introduction of HB 2096 assures the Legislature of that opportunity this session.

Our support for HB 2096 is based on two critical factors -- the potential negative effect of the current law on hospital patients and its equally negative potential for health care providers.

The legislation passed last session gives Blue Cross and Blue Shield of Kansas the statutory right to refuse to honor a patient's wishes that his or her benefits be assigned to the treating health care provider. In addition to removing a patient's freedom to contract, the law places the patient in a difficult and awkward position. Instead of being able to freely assign their benefits and therefore be free from the worry of personal payment of sometimes large

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medical bills, patients are now in the position of having to personally carry out a function they feel should be performed by their insurer.

The current law also creates problems for health care providers. By requiring patients to make difficult choices about what bills to pay with benefits received, the law will likely increase the amount of uncompensated care provided. In addition, it will require providers to spend more time and resources in collection efforts. Our system of reimbursement for health care services is already inefficient. Without passage of HB 2096 matters stand to get worse.

Thank you for your consideration of our comments.

TLB / pc

BRAD SMOOT

ATTORNEY AT LAW

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STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL
BLUE CROSS & BLUE SHIELD OF KANSAS
IN THE HOUSE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE
REGARDING 1993 HOUSE BILL NO. 2096

FEBRUARY 15, 1993

Mr. Chairman and Committee Members:

As you know, H-2096 was requested by a Wichita hospital to remove language from legislation passed in the 1992 Session regarding health insurance contracts with providers and the assignment of benefits under insurance policies. Blue Cross Blue Shield of Kansas and others oppose H-2096 because of the dramatic negative impact it will have on health care (and correspondingly, health insurance) costs for thousands of Kansans. Because of the complexity of insurance laws and confusion being created by publicity on this subject, I have provided those of you who requested it a review of the subject matter and the history of this controversy before these hearings. To many of you I also provided a copy of the recent Federal District Court case on this subject and several copies are included with this Statement.

When an employer or individual enters into a health insurance contract, he or she agrees to pay premiums in exchange for the insurance company's promise to make payment for certain medical and hospital services should they be required. The obligations under the insurance contract are between the company and its insured. Often, however, when a person seeks medical and hospital services, the provider requires the person to sign over to the provider the person's right to reimbursement from the insurance company. This transfer of reimbursement to the provider is known as "assignment" of benefits and entitles the provider to be paid directly by the insurance company. Such agreements benefit the providers since they do not have to rely on the insured to pass on the insurance money.

For years BCBS has refused to honor such "assignments" and instead has entered into contracts directly with hospitals, physicians and other medical providers for the payment of insurance proceeds. Over the years we have contracted with virtually every provider in Kansas, and until just this year, with every hospital. Under the BCBS system, the insureds still receive medical treatment and the providers still receive direct reimbursement if they have a

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Attachment 6

contract with BCBS. The advantage for the insureds of BCBS is that BCBS negotiates a reimbursement rate with providers that is less than might otherwise be charged. In addition, providers agree not to bill the BCBS-insured patient for any excess above the agreed contract price. Such excess charges are known as "balance billing."

Through the use of hundreds of provider contracts, BCBS, Kansas' largest and only domestic insurance company, saves millions of dollars per year in medical costs and insurance premiums. In our view, this is real health care cost containment.

Over the years the BCBS system has worked well and has been accepted by virtually every provider of medical services. On occasion, a provider seeks to upset this system through litigation. In 1981, the Augusta Medical Complex filed suit to force BCBS to honor assignments (pay them directly even if they did not negotiate a contract with BCBS). The Supreme Court of Kansas rejected the Augusta Medical Complex attack and held in favor of the BCBS system, noting that "(h)ealth care cost containment is a matter of vital public interest and policy." Augusta Medical Complex, Inc. v. Blue Cross, 230 Kan. 361, 365 (1981).

In 1991 the Kansas Legislature directed BCBS to convert its business structure from that of a nonprofit medical and hospital service corporation into a mutual insurance company. See 1991 House Bill 2001. In so doing, the Legislature did not make a policy decision to change the way BCBS had been contracting for these many years. On the contrary, the Legislature took great pains to protect the "contract rights" of BCBS through the use of the following language now contained in K.S.A. 1992 Supp. 40-19c12: "The existing contract rights and obligations of such corporation, of subscribers and of health care providers shall not be impaired by such conversion to mutual status."

In 1992, some concern was expressed that the above-cited language of H 2001 was not broad enough to protect BCBS contractual relationships and that the law should be further clarified. The Insurance Department requested that an amendment be added to Senate Bill 66, which concerned other technical corrections to H 2001, to clarify the Legislature's intent not to strip BCBS of its long-standing ability to negotiate with providers. The Conference Committee accepted the Department's suggested language on this (and another

change affecting HMO's) and added the following: "The agreements issued by any corporation currently or previously organized under this act may include provisions allowing for direct payment of benefits only to contracting health care providers." L. 1992, Ch. 196, Section 1(b), amending K.S.A. 1991 Supp.40-19c06.

Following the passage of S 66 by the Legislature, the Wichita hospital that now seeks to remove the BCBS contracting rights sought a gubernatorial veto. Governor Finney listened to all their arguments, rejected them and signed S 66.

One issue unique to the Wichita hospital situation is worthy of note at this point. As you know, BCBS made a decision to seek bids for hospital services in the Wichita area. Wichita is a highly competitive health care arena (as you will no doubt hear during the hearings on H 2096) and BCBS wanted to get the best price available for its insureds. In order to do that, we asked the larger Wichita hospitals to bid on BCBS business and announced that we would contract with only two of the three. HCA Wesley submitted a bid. St. Francis and St. Joseph did not choose to bid.

Undaunted, one Wichita hospital began an aggressive media campaign, taking out full-page ads in large newspapers complaining about the situation and pledging to file suit. Suit was filed November 9th in state court and moved to federal district court in Wichita later in the same month. After hearing extensive legal argument and volumes of legal briefs, Federal District Court Judge Patrick Kelly rejected the hospital's suit, finding instead for BCBS on all counts.

The decision is not only a victory for BCBS's insureds, it also rings with support for the health care cost containment efforts of the Kansas Legislature. Throughout the opinion, Judge Kelly notes various legislative efforts to control medical costs, and in particular he affirmed the action of the 1992 Legislature in enacting S 66, which the proponents of House Bill 2096 now seek to undo. In addition, the judge rejected the arguments you will be hearing from those proponents about the public policy regarding assignments. In short, the judge ruled on the side of cost containment and freedom of contract. Although the decision is long and sometimes complicated, you may find it interesting.

At last we come to the current legislation, H 2096 which represents the Wichita hospital's latest effort to undo years of successful health care cost containment by removing BCBS ability to refuse assignments and contract separately with providers. It is hard to imagine that an issue as technical as the right to refuse assignments could create such a "flap," but as we discussed, this issue is really all about money. I am certain you will get an opportunity to hear a great deal about the fiscal impact of H 2096. I trust you will make every effort to continue the Legislature's efforts to restrain health care costs and continue the ability of insurers to assist in that cost containment effort.

Thank you for your attention and I urge you to oppose the passage of H-2096.

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The Wichita Eagle

BUSINESS & FARM

WEDNESDAY December 30, 1992

Blue Cross wins contract dispute

Federal judge dismisses St. Francis suit over claims reimbursement

By Anne Fitzgerald
The Wichita Eagle

A federal district judge on Tuesday cleared the way for Blue Cross Blue Shield of Kansas to proceed with its plan to reimburse hospital patients directly after Thursday unless hospitals have a contract with the insurer.

After hearing several hours of arguments from attorneys for Blue Cross and St. Francis Regional Medical Center, Judge Patrick Kelly took less than an hour Tuesday afternoon to dismiss a lawsuit brought in November by St. Francis against the insurer.

St. Francis sought an injunction to prevent Blue Cross from carrying out its plan and to preserve patients' right to assign insurance benefits to hospitals.

Patients who don't want to bother with the paperwork of insurance claims prefer assigning the insurance benefit to the billing hospital. And hospitals know that the insurance payments will come to them directly.

In its arguments, St. Francis questioned the constitutionality of legislation passed earlier this year that allows Blue Cross to make direct payments only to hospitals with which it has a contract.

Without the contract, the insurer will pay patients directly — and patients will have to file the forms and seek the payment — beginning Friday.

In Wichita, only HCA Wesley Medical Center and Riverside Hospital have negotiated new contracts with Blue Cross. St. Joseph Medical Center has a contract with the insurer to allow assignment of benefits only when the services aren't available at Wesley.

At best, St. Francis claimed, the change would delay payments to hospitals without a contract with Blue Cross; at worst, hospitals would lose money if patients didn't use their insurance reimbursements to pay their bills.

Blue Cross had asked that the case be dismissed, alleging that it was acting within the law and that its plan would help contain health-care costs through the negotiated contracts, which set specific charges for hospital services.

Kelly said St. Francis had failed to prove its claims. "I appreciate that St. Francis may sustain some economic losses," he said.

Alan Rupe, a Wichita attorney representing Blue Cross, said the most important part of the decision was its affirmation that assignment could be used to contain health-care costs.

"It's certainly a victory for every health-care consumer in Kansas," he said, "because it allows Blue Cross Blue Shield a mechanism to exercise cost containment."

St. Francis officials were surprised and disappointed by the judge's decision.

"We thought that we would have prevailed. We expected injunctive relief," said Bruce Carmichael, a vice president at St. Francis.

He said St. Francis officials will wait to review Kelly's opinion, he said, before deciding whether to take any additional action.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

ST. FRANCIS REGIONAL MEDICAL CENTER,

Plaintiff,

vs.

BLUE CROSS BLUE SHIELD OF KANSAS, INC.,

Defendant.

No. 92-1580-PFK

MEMORANDUM AND ORDER

The plaintiff, St. Francis Regional Medical Center, a nonprofit Kansas corporation, has brought the present action against Blue Cross Blue Shield of Kansas, Inc., seeking a determination that recent state legislation relating to Blue Cross is unconstitutional and that portions of the insurance policies issued by Blue Cross violate public policy. Specifically, St. Francis contends that the nonassignment clause utilized by Blue Cross in its insurance policies violates the Kansas public policy supporting free assignment of choses of action. St. Francis also contends that Senate Bill No. 66, L. 1992, Ch. 196 (amending K.S.A. 40-19c06), violates the prohibition on special legislation and the guaranty of equal protection contained in the Kansas Constitution.

This action was originally filed by St. Francis in Sedgwick County District Court. On November 30, 1992, the action was removed by Blue Cross to this court. Blue Cross moved to dismiss the action on December 7. On December 16, St. Francis moved for a

preliminary injunction preventing Blue Cross from "refusing to honor assignments" made by Blue Cross insureds to St. Francis after the current provider agreement between Blue Cross and St. Francis expires at the end of this month. St. Francis filed its brief in support of this motion for injunctive relief five days later. A hearing on the present matter was originally set for December 22. At the request of the parties, the hearing was set over for one week. On December 29, 1992, the court conducted a hearing in which the parties were extended the opportunity to address the issues raised by the motions submitted to the court. In addition, during the course of this hearing, the parties also introduced into the record certain stipulations for purposes of resolving the motion to dismiss. At the conclusion of the hearing, the court found that the present action should be dismissed. Consistent with the statements of the court at that time, and for the reasons explained more fully herein, the court hereby grants defendant Blue Cross's motion to dismiss.

Blue Cross is currently a mutual life insurance company organized under K.S.A. 40-501. Traditionally, however, Blue Cross operated as a nonprofit medical and hospital service company organized under K.S.A. 40-19c01. In 1991, the state legislature enacted K.S.A. 40-19c12, requiring Blue Cross to convert to either a mutual life insurance company under Article 5 of Chapter 40, or a mutual company other than life under Article 12 of Chapter 40. Blue Cross became a mutual life insurance company on July 1, 1992, pursuant to the election required by K.S.A. 40-19c12.

As a nonprofit insurer under Article 19c, Blue Cross was expressly required by the legislature to adopt procedures to control the growth of health care costs. One of the tools Blue Cross has utilized in fulfilling that mandate has been the use of provider agreements with health care providers, coupled with clauses in its insurance policies prohibiting the assignment of benefits.

If a health care provider has not entered into a contracting provider agreement with Blue Cross, persons receiving services from that provider cannot assign their benefits to Blue Cross directly. Instead, the insured person must pay the provider, and then seek reimbursement from Blue Cross. On the other hand, if a health care provider has obtained a contracting provider agreement with Blue Cross, it may bill Blue Cross directly for any services rendered.

Under the contracting provider agreement, the hospital agrees to accept payment from Blue Cross as payment in full, and to hold the insured harmless for any balance in excess of Blue Cross's maximum allowable payment. The contracting provider agreement also provides for Blue Cross review of hospital services and other cost containment devices.

This system was upheld by the Kansas Supreme Court in Augusta Medical Complex v. Blue Cross, 230 Kan. 361, 634 P.2d 1123 (1981). In that case, a group of Kansas hospitals challenged Blue Cross's use of nonassignment clauses in its insurance policies, contending that these provisions violated a general public policy favoring free assignment of choses in action. The supreme court held that

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this policy was insufficient to invalidate the nonassignment clauses at issue, given the legislative mandate extended to Blue Cross to contain skyrocketing hospital costs.

On April 16, 1992, Blue Cross issued a request for proposal to all Wichita hospitals having more than two hundred beds. There are three hospitals of this size in Wichita. The request invited these hospitals to submit competitive bids for provider contracts with Blue Cross, under which two hospitals would be chosen as contracting hospitals effective January 1, 1993.

Only one hospital, HCA Wesley Medical Center, responded. Neither of the other hospitals, including St. Francis, issued any bid. In subsequent correspondence, St. Francis confirmed its intention not to submit a bid with Blue Cross under the terms of the request for proposal.

In response to Blue Cross's motion to dismiss, St. Francis has argued that the motion actually seeks summary judgment and contends that it is premature to grant that relief at this time. Toward that end, St. Francis has filed an affidavit pursuant to Fed.R.Civ.P. 56(f) stating that further discovery needs to be completed. The court finds that Blue Cross's motion is appropriately addressed as a motion to dismiss. The issues raised in that motion are purely legal in nature, and the court finds that they may be decided without resort to making findings of fact not contained in St. Francis's complaint.

Although St. Francis has repeatedly emphasized the allegedly wrongful conduct of Blue Cross during the discourse between the

parties during 1992, that conduct is not at issue here. St. Francis has not, for example, asserted claims of estoppel or detrimental reliance against Blue Cross in an attempt to preserve its existing provider care contract with that company. Rather, it has sought a legal determination that the nonassignment clauses are inherently illegal. Thus, while issues of the relative economic impact of the termination of the existing contractual relationship and the underlying subjective motivations of the parties which led to that termination might be relevant to such a claim (or to St. Francis's motion for injunctive relief), they are not relevant to the issue currently before the court: whether the state legislature's enactment of Senate Bill No. 66 offends various provisions of the Kansas Constitution, or whether nonassignment clauses represent a per se violation of Kansas public policy.

This court has previously addressed the use of Blue Cross contracting provider agreements in Reazin v. Blue Cross & Blue Shield, 635 F.Supp. 1287 (D. Kan. 1986) and 663 F.Supp. 1360 (D. Kan. 1987). The various federal antitrust claims raised in Reazin have not been raised here. The court held that Augusta was not controlling in that case since the termination of the provider agreement there occurred by the unilateral action of Blue Cross. The plaintiff hospital wished to maintain a provider agreement with Blue Cross, but the insurer both terminated the provider agreement and refused to offer the hospital any new provider agreement. The court noted that under these circumstances "there was no question of a hospital refusing to join." 635 F.Supp. at 1334. In the

present case, on the other hand, St. Francis was extended the opportunity to bid, which it declined to exercise.

I. ERISA Preemption

In its motion to dismiss, Blue Cross contends that the majority of its policies are employee health benefit policies covered under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq., and that any state law requiring free assignment is preempted by federal law. Under 29 U.S.C. § 1144(a) (§ 514(a) of ERISA), the federal act preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

The Supreme Court has broadly interpreted the "relates to" language of ERISA preemption. Shaw v. Delta Air Lines, 463 U.S. 85, 98 (1983). A state law "relates to" an employee benefit plan when it has "a connection with or reference to such a plan." Id. at 96-97. Under this test, a state law may be preempted if it relates to an ERISA plan, even if the law was not specifically intended to affect such a plan or if the effect is only indirect. Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990). On the other hand, a law does not relate to an ERISA plan within the meaning of the preemption statute if it affects the plan only in a "tenuous, remote, or peripheral" manner. Shaw, 463 U.S. at 100 n. 21.

Observing that there was no "simple test" for resolving the question of whether a given law "relates to" a plan, the Tenth Circuit has noted that cases finding such a relationship follow four general types.

> First, laws that regulate the type of benefits or terms of ERISA plans. Second, laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans. Third, laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans. Fourth, laws and common-law rules that provide remedies for misconduct growing out of the administration of the plan.

National Elevator Industry v. Calhoon, 957 F.2d 1555, 1558-59 (10th Cir.), cert. denied, ___ U.S. ___, 113 S.Ct. 406 (1992) (quoting Martori Bros. Distrib'rs v. James-Massengale, 781 F.2d 1349, 1356-57 (9th Cir.), cert. denied, 479 U.S. 1018 (1986)). See also Monarch Cement v. Lone Star Industr., ___ F.2d ___, 1992 WL 374045 (10th Cir. Dec. 22, 1992); Kelso v. General American Life Ins., 967 F.2d 388 (10th Cir. 1992); Aetna Life Ins. v. Borges, 869 F.2d 142, 146-74 (2d Cir.), cert. denied, 493 U.S. 811 (1989) (a law relates to an ERISA plan if it has "an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit"). ERISA preemption is designed in part to ensure that plans and their sponsors are subjected to a uniform body of benefit law, thereby preventing inefficiencies working to the detriment of plan beneficiaries. See Monarch, at 5 (citing Ingersoll-Rand, 111 S.Ct. at 484).

The court finds preemption here. The general state case law favoring free assignability of benefits would, if found applicable herein, directly affect the plan by nullifying one of the most important provisions contained in the plan. It would directly affect the level of benefits each employee could expect under the plan. And it would seriously affect the administration of the

plan. Finally, preemption fits with the purposes of ERISA preemption, since a contrary finding would greatly impair the ability of each plan sponsor to obtain similar benefits.

The Eighth Circuit has addressed a similar situation. In Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, 947 F.2d 1341, 1344-45 (8th Cir. 1991), cert. denied, ___ U.S. ___, 119 L.Ed.2d 227, 112 S.Ct. 2305 (1992), the court held that an Arkansas statute mandating the assignability of insurance benefits was preempted by ERISA.[1] The court found that the statute related to the plan since it would (1) negate a provision contained in an ERISA plan (by nullifying the effect of the nonassignment clause); (2) have a direct impact on ERISA entities and the structure of the plan; (3) have a direct impact on administration of the plan; and (4) have an economic impact on the plan. The court further found that application of ERISA was consistent with other provisions, specifically 29 U.S.C. § 1056(d)(1), which provides express limitations on assignability of pension benefits.

In its response, St. Francis relies entirely on the decision of the Supreme Court in Mackey v. Lanier Collections Agency & Service, 486 U.S. 825 (1985), in which the Court held that a state garnishment law was not preempted by ERISA. The decision in Mackey

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[1] Ark. Code Ann. § 4-58-102 (1987) provides that "[a]ll bonds, bills, notes, agreements, and contracts, in writing, for the payment of money or property, or for both money and property, shall be assignable." The Arkansas Supreme Court has held that this provision requires Arkansas Blue Cross & Blue Shield to honor any assignment of insurance benefits made by a plan beneficiary. American Medical Int'l v. Arkansas Blue Cross & Blue Shield, 299 Ark. 514, 773 S.W.2d 831 (1989).

was addressed at length by the Eighth Circuit in Arkansas Blue Cross, and found to be distinguishable. Unlike the assignment statute which was before it, the Eighth Circuit pointed out that

> state garnishment and escheat statutes do not shift control over benefit distribution. Neither do they negate a proper ERISA provision. Additionally, in Mackey, the Supreme Court significantly relied on a "sue and be sued" clause in the ERISA statute as support of its holding. The Court reasoned that because the "sue and be sued" clause contemplates execution of judgments but does not provide a method for doing so, state law methods for collecting money judgments must remain undisturbed. Mackey, 486 U.S. at 833-34, 108 S.Ct. at 2187. This "sue and be sued" language is not applicable to the voluntary assignment of ERISA benefits. Accordingly, Mackey does not control the issue before this court.

947 F.2d at 1347-48.

The Eighth Circuit also found the decision in Mackey distinguishable on the basis of the explicit Blue Cross plan language barring assignments. In Mackey, the Supreme Court based its decision, that employee welfare benefits were subject to garnishment, upon the fact that Congress, while explicitly prohibiting any assignment of pension benefits under 29 U.S.C. § 1056(d)(1), had not explicitly barred the assignment of welfare benefits. As the Eighth Circuit pointed out, the Mackey decision was not applicable to the issue before it, since the failure of Congress to expressly legislate the legality of the assignment of welfare benefits "does not mean that Congress left the door open for states to impose such a rule. If Congress intended that a mandatory rule govern the assignment of welfare benefits, it could have easily provided for such a rule, as it did in the case of pension benefits." 947 F.2d at 1349. Unlike the preemption of

state laws governing garnishment, which would essentially overlap the bar on assignments under § 1056(d)(1), ERISA preemption of state law as to the assignability of claims does not. Instead, it merely leaves to each plan the option of whether to permit assignment. Id. at 1350.

Other courts have reached similar results. Thus, in Washington Hospital Center v. Group Hospitalization & Medical Services, 758 F.Supp. 750, 735 n. 2 (D.D.C. 1991), the court held that Congress's silence on the assignability of health benefits indicates that such assignments are not prohibited as a matter of law, "but such silence does not suggest an affirmative policy favoring assignments so strong as to invalidate otherwise valid anti-assignment clauses."

In Davidowitz v. Delta Dental Plan, 946 F.2d 1476, 1779 (9th Cir. 1991), a group of dentists sought a preliminary injunction requiring that the defendant nonprofit health care plan honor assignment of benefits under the plan. The dentists asserted that ERISA required assignability of benefits, citing Mackay and a California case, Franchise Tax Board v. Construction Laborers Vacation Trust, 204 Cal.App.3d 955, 251 Cal. Rptr. 597 (1988), in which the court held that ERISA did not preempt a state tax law permitting a levy on benefits of a plan containing a nonassignment clause. The Ninth Circuit found neither case applicable to the issue before it, stating

> the garnishment cases cannot be stretched that far. They simply hold that state law may provide a statutory mechanism for judgment collection, and such state procedure is not preempted by ERISA. The Franchise Tax

> Board case noted that voluntary agreement to a non-assignment clause could not displace that un-preempted procedure. Here, the dentists do not rely on a separate statutory right or process that requires voluntary assignments be honored. Thus, the question remains whether ERISA itself mandates assignability, and the garnishment cases provide no assistance in that analysis.

946 F.2d, at 1479. The Davidowitz court concluded that ERISA did not invalidate the nonassignment clause, finding "that Congress intended not to mandate assignability, but intended instead to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as might evolve." 946 F.2d, at 1481 (emphasis in original).

St. Francis correctly notes that not all of the policies issued by Blue Cross are employee benefit policies. It also notes that some Blue Cross plans may be employee benefit plans but still not fall under ERISA, since, for example, they may have been issued by a government or by a religious institution. 29 U.S.C. § 1003(b).

This does not alter the result, since even as to plans which do not fall within ERISA, St. Francis's claims fail on the merits.

II. State Law

A. Constitutional Claims -- Standing

The court must agree with Blue Cross that St. Francis does not have any standing to assert the specific constitutional claims advanced against Senate Bill No. 66. The constitutionality of a law may not be attacked by a party who invokes not his own but the rights of others. Manzanares v. Bell, 214 Kan. 589, 616, 522 P.2d

1291 (1974). See also City of Kansas City v. Union Pac. Ry., 59 Kan. 427, 53 P. 468 (1898), aff'd, 176 U.S. 114 (1900).

St. Francis claims standing on the basis of two decisions, Delight Wholesale v. City of Overland Park, 203 Kan. 99, 453 P.2d 82 (1969); and Joe Self Chevrolet v. Board of Sedwick Co. Com'rs, 247 Kan. 625, 802 P.2d 1231 (1990). In Delight Wholesale, the City of Overland Park passed a local ordinance prohibiting all street or sidewalk "huckstering, peddling or similar enterprise." The plaintiff, a franchiser of frozen novelties, brought an action against the city, claiming that the ordinance was an unreasonable exercise of police powers.

The court's discussion of standing is essentially dicta. There is no indication in the opinion that there had been any challenge to the plaintiff's standing. Rather, the court raised the issue of standing only in the context of a lyrical digression by the court. After first noting that the city ordinance would effectively bar all direct sales on the streets of the city, the court observed:

> This would prohibit farmers from selling watermelons, tomatoes and other fresh vegetables from their vehicles. Such sales are about the only opportunity we have to know the difference between a red, juicy watermelon and a sun-kissed tomato all ripened on the vine from those picked green and ripened in the dark recesses of a warehouse. It would also prohibit the old fruit peddler who perhaps is only a nostalgic memory of the past-- "Yes, we have no bananas."

203 Kan. at 100.

Bringing itself back to the case before it, the court then correctly observed that these hypothetical plaintiffs were not

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before the court. And the court reiterated its general rule of standing, "that the constitutionality of governmental action can only be challenged by a person directly affected and such challenge cannot be made by invoking the rights of others." Id. at 101 (citations omitted). The court did not directly address the issue of the standing of the plaintiff which had brought the lawsuit.

However, even assuming that the Supreme Court had actually considered the question of plaintiff's standing, there are several circumstances present in Delight Wholesale which make the case distinguishable from the present controversy. In that case, the plaintiff was challenging the ordinance on the basis of an abuse of the city's police powers, claiming that the ordinance represented "unreasonable or oppressive legislation." Id. at 103. The plaintiff, in seeking to limit the city's police powers to that which is necessary to protect the safety, health, and general welfare of citizens, was thus advocating a right, seeking which inheres in all citizens. In the present case, on the other hand, St. Francis's claims of special legislation and equal protection essentially raise claims which belong more properly to other insurance companies. When brought by St. Francis, these claims can only be seen as an attempt, as the court in Delight Wholesale put it, to "invok[e] the rights of others."

In addition, the city ordinance in that case directly affected the plaintiff. The plaintiff company had issued franchises to dealers, who purchased and then resold to the general public various frozen novelties. In addition, these novelties were sold

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to the public from jeeps which had been leased by the local dealers but which were still owned by the plaintiff company. On the other hand, in the present case, St. Francis is not directly affected by the provision contained in Senate Bill No. 66 permitting Blue Cross to continue to include nonassignment provisions in its policies. Of course, it may be true, as St. Francis argues, that these provisions will ultimately result in an economic loss to the hospital. But this indirect economic impact alone cannot satisfy the requisites for standing.

The second case cited by St. Francis is Joe Self Chevrolet v. Board of Sedwick Co. Comirs, 247 Kan. 625, 802 P.2d 1231 (1990). In that case, Sedwick County, Kansas had seized a truck from George and Janet Hays for delinquent personal property taxes. The county claimed that under K.S.A. 79-2111, the nonpayment of property taxes entitled it both to the seizure of the truck and a preference to the proceeds from its sale. The Hayses subsequently defaulted on their payments on the truck, and the used car dealership which sold them the truck and which retained a security interest in it filed a declaratory judgment action seeking a declaration either that K.S.A. 79-2111 created no such preference in favor of the county, or that the statute was unconstitutional.

The county argued that the car dealer, who was not a party to the tax litigation involving the Hayses, had no standing to determine the constitutionality. The supreme court, after repeating the general rules relating to standing, held that the dealer had the right to file the declaratory judgment action. In

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doing so, the court first stressed the dealer's continuing property interest in the truck:

> If a seller retains an interest in goods sold to secure payment of some or all of the price, he has a purchase money security interest. The security interest can be perfected by the filing of a financing statement. Joe Self retained an interest in the GMC truck and filed its financing statement. A secured creditor with a lien on the property has a due process right in the property seized. See Hillhouse v. City of Kansas City, 221 Kan. 369, 375, 559 P.2d 1148 (1977) (citing Mitchell v. W.T. Grant Co., 416 U.S. 600, 40 L.Ed.2d 406, 94 S.Ct. 1895 (1974)).
>
> Under the facts of this case, [the car dealer], a secured creditor, has sufficient interest in the justiciable controversy to obtain a judicial resolution as to the constitutionality of K.S.A. 79-2111 in a declaratory judgment action.

247 Kan. at 629.

Unlike the car dealer in Joe Self, St. Francis has no continuing property interest which is directly affected by Senate Bill No. 66. Rather, the hospital is only indirectly affected by the continued operation of the nonassignment clauses legitimized by that legislation. To hold that this indirect economic impact was sufficient to challenge the validity of Senate Bill No. 66 under the Kansas Constitution would be inconsistent with the rules of standing which have been set forth by the Kansas courts.

B. Constitutional Claims

St. Francis's constitutional claims also fail on the merits. St. Francis asserts that Senate Bill No. 66 represents special legislation and violation of equal protection. The court must presume the statute is valid. Guardian Title v. Bell, 248 Kan. 146, 805 P.2d 33 (1991). Any constitutional infirmity must be

clearly demonstrated, and the court must uphold the statute if it is possible to do so. Kansas Malpractice Victims Coalition v. Bell, 243 Kan. 333, 340, 757 P.2d 251 (1988).

Article 12, § 1, of the Kansas Constitution provides, "The legislature shall pass no special act conferring corporate powers. Corporations may be created under general laws, but all such laws may be amended or repealed."

Section 1 of the Kansas Bill of Rights provides, "All men are possessed of equal and inalienable natural rights, among which are life, liberty, and the pursuit of happiness."

St. Francis has failed to demonstrate that Senate Bill No. 66 offends either constitutional provision. The act does not create unfair distinctions between existing corporations, nor does it unfairly create separate classification among existing members of one class. Moreover, the act does not create classifications within an existing class of corporation. Rather, Senate Bill No. 66, by its terms, applies to all former nonprofit hospital service companies. It may be that Blue Cross is the only member of that class. That fortuitous circumstance alone does not render the act impermissible special legislation. See Board of Sedgwick Co. Com'rs v. Robb, 166 Kan. 122, 199 P.2d 530 (1948), appeal dismissed, 336 U.S. 957 (1949); State ex rel. Smith v. McComba, 129 Kan. 834, 284 P. 618 (1930). Rather, the controlling factor is that the legislation does not unfairly create classifications within the group of former nonprofit hospital service companies.

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Nor is there anything in the legislation to suggest that Blue Cross, as it is now constituted, possesses any powers which are not enjoyed by other mutual life insurance companies. That is, there is nothing in the Kansas statutes which bars other insurance companies from including nonassignment clauses in their policies. Whether such clauses are valid in a given case is, of course, a question of whether applicable public policy permits such a clause. That issue is addressed below. The point here is that there is no indication Senate Bill No. 66 does anything other than permit Blue Cross to act as it has for many years by offering policies which include nonassignment clauses. This legislative mandate reflects the legislature's continuing concern with the costs of health care, and reflects a considered and rational attempt to address that problem.

C. Public Policy

The core of St. Francis's argument is that the nonassignment clauses contained in the Blue Cross policies violate the Kansas public policy favoring free assignment of choses in action. St. Francis contends that, since the cost control provisions cited by the court in Augusta Medical Complex v. Blue Cross, 230 Kan. 361, 634 P.2d 1123 (1981), no longer are directly applicable to Blue Cross in its incarnation as a mutual life insurance company, that decision no longer supports the validity of the nonassignment clauses in the company's policies.

In challenging the validity of the nonassignment clauses, the burden is on St. Francis to demonstrate that the nonassignment

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clauses do indeed violate public policy. 4 Corbin on Contracts, § 872 (1951). In the context of health care insurance, such clauses have been generally upheld as a vital tool in restraining the costs of health care. Parrish v. Rocky Mountain Hosp. & Med. Serv. Co., 754 P.2d 1180 (Colo. App. 1988); Obstetricians-Gynecologists, P.C. v. Blue Cross & Blue Shield, 219 Neb. 199, 361 N.W.2d 550 (1985); Kent General Hospital v. Blue Cross & Blue Shield, 442 A.2d 1368 (Del. Supr. 1982).[2]

St. Francis has cited no case from any jurisdiction striking down such nonassignment clauses, when used as part of a strategy for the containment of health care costs, as a violation of general public policy. Instead, St. Francis relies entirely upon its citation to the decision of the Kansas Supreme Court in Augusta. In that case, the court stated:

> Free assignment of choses in action is considered to be a matter of public policy. However, other considerations of public policy may in particular instances compete with and override the desirability of free alienation of choses in action.

230 Kan. at 364.

The supreme court in Augusta, while noting that free assignment was a good thing, nonetheless found that that policy was

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[2] There are also a number of state trial court decisions which reach the same result. See Institute of Living v. Blue Cross & Blue Shield, Case No. CV-90-0382398S, 1991 WL 223871 (Conn. Super. Oct. 4, 1991); Beebe Hospital v. Blue Cross & Blue Shield, Case No. 6456, 1981 WL 15133 (Del. Ch., June 26, 1981); Board of Trustees v. Rocky Mountain Hospital & Medical Service, Civ. Case No. 81-CV-385 (Wald County Col. Dist. Ct. 1981); Riddle Mem. Hospital v. Blue Cross, 63 Pa. Del. Cty. 361 (Pa. Common Pleas, 1976).

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counterbalanced by Blue Cross's legislative mandate to achieve controls on the costs of health care. The court at no time suggested or implied that, in the absence of specific statutory authorization for particular cost containment procedures, the policy of free assignment must control. Rather, the language of the opinion indicates that while free assignment may be desirable generally, there may still be "other considerations of public policy" which support the validity of nonassignability clauses, beyond even the absence of specific statutory authorization for cost containment.

The court does not believe that free assignment of choses in action is so compelling a public policy that the nonassignment clauses contained in the Blue Cross policies are void.

First, there is a countervailing policy which balances free assignment of choses in action: the freedom to contract. Kansas courts have repeatedly recognized that the freedom to contract is an important public policy. State "public policy encourages the freedom to contract, which should not be interfered with lightly." Miller v. Foulston, Siefkin, 246 Kan. 450, 790 P.2d 404, 413 (1990). Absent a specific finding of unconscionability, a party is bound by an agreement fairly and voluntarily entered into, notwithstanding it was unwise or disadvantageous to him. Corral v. Rollins Protective Services, 240 Kan. 678, 732 P.2d 1260 (1987).

Other courts which have addressed similar situations have also stressed the importance of freedom to contract as a counterbalance to the policy of free assignment. The Colorado Court of Appeals

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has noted that "the policy of free alienability of choses in action can be overcome by the strong policy of freedom of contract." Parrish v. Rocky Mountain Hosp., 754 P.2d 1180, 1182 (1988). In Obstetricians-Gynecologists, the Nebraska Supreme Court observed:

> While this policy [of free assignability] is significant and may reflect a public policy, it is not paramount and must be balanced against a very strong policy, recognized in many cases in Nebraska and in authoritative texts, favoring the freedom to contract.

361 N.W.2d at 555.

How important is the public policy supporting the free assignment of choses in action? St. Francis has failed to identify any particular compelling nature in that general public policy. And, while Kansas cases have recognized that public policy supports the free assignment of choses in action, Augusta, 230 Kan. at 364, no decision has ever attempted to quantify the strength of this public policy. Indeed, the court in Augusta, while recognizing the general existence of the policy, at most merely documented its existance. It did not sing any paeans to the importance of the policy. The court has found no decision which characterizes the policy as particularly compelling. Rather, at most the case law indicates that assignments of choses in action "are recognized and enforced;" Commodore v. Armour & Co., 201 Kan. 412, 418, 441 P.2d 815 (1968), indicating simply that such assignments are permitted rather than preferred.

At one time, Kansas had a specific statute legitimizing the assignment of choses in action. G.S. (1949) 60-401 expressly affirmed the legality of such assignments. That statute has since

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been repealed. Another statute, K.S.A. 40-440, acknowledges the existing right to assign interests under an insurance policy. But, like the Commodore decision, this merely affirms the validity of such assignments in general; it does not guarantee the universal right to assign benefits by voiding contractual agreements limiting the scope of assignment.[3] Moreover, the state legislature has explicitly recognized that the policy of favoring free assignability is not always superior to other interests by prohibiting by statute assignability in certain cases. See K.S.A. 16a-3-305 (limiting assignment of wages); K.S.A. 44-514 (prohibiting assignment of workers compensation benefits).

Thus, while the free assignment of choses in action may be a valuable and important goal of public policy, it is not superior to competing public interests. The policy supporting free alienability is not "such an absolute one that it must override a contract provision prohibiting assignment in a specific context." Kent, 442 A.2d at 13. As one commentator has observed,

> There is no sufficient analogy between chattels and "choses in action" on which to rest the conclusion that

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[3] The situation in Kansas can thus be contrasted with a state such as Arkansas, which provides by statute that:

> All bonds, bills, notes, agreements, and contracts, in writing, for the payment of money or property, or for both money and property, shall be assignable.

Ark. Cod. Ann. § 4-58-102 (1987) (emphasis added). The mandatory nature of this statute underlies the only reported decision striking down nonassignment clauses in the context of a system designed to limit the growth of health care costs, American Medical Internat'l v. Arkansas Blue Cross & Blue Shield, 299 Ark. 514, 773 S.W.2d 831 (1989).

> contract rights, once inalienable at common law, must now of necessity be alienable even though the contract by which they are created says that they are not. In all cases, assignees are held to take the assigned right with all its native weaknesses and subject to many defenses.

4 Corbin on Contracts § 873, p. 488.

The public policy supporting free assignment is not, therefore, an unqualified one. Against that policy must be set the competing policy of freedom of contract. But there is also a third policy which must also be considered: the policy of attempting to restrain the growth of health care costs. That policy and that need have been recognized by the legislature and the courts of Kansas.

It may be noted first that although the cost control provisions contained in Articles 18 and 19c of Chapter 40 no longer directly apply to Blue Cross, those provisions remain in effect. The legislature could have repealed those provisions but it chose not to do so, indicating that cost control in the health services industry remains a concern in Kansas.

That concern, moreover, has been repeatedly emphasized by the legislature. The control of the explosion of health care costs has formed a recurrent theme in recent legislation. Under K.S.A. 65-4915(a)(3)(5), the legislature has encouraged the use of peer review programs which serve to "establish and enforce guidelines designed to keep within reason the cost of health care." Under K.S.A. 65-4804, the construction of new health care facilities is made dependent upon the certification of need, which must take into account cost containment, defined as "lowering, or restricting the

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increase, of health care costs to the consuming public." Maximum fee schedules for health care services under the state Workers Compensation Act have been imposed which are explicitly required to "promote health care cost containment and efficiency." K.S.A. 44-510(a)(2). The legislature has required that, prior to the consideration of any legislation providing for mandated health benefits, the party sponsoring such legislation must report the effect of its proposals on the total costs of health care. K.S.A. 40-2249(b)(5). Finally, the legislature has recently created the Kansas Commission on the Future of Health Care, Inc. K.S.A. 74-9401 et seq. One of the express purposes of this corporation is the formation of task forces to study ways to control health care costs. K.S.A. 74-9403(a)(8).

This public interest has also been recognized by the Kansas Supreme Court, which recognized in Augusta that the Blue Cross provider agreement system had been adopted out of a concern for "spiraling hospital service costs" 230 Kan. at 361. "The concern over skyrocketing health care costs is real and nationwide," the court wrote in Augusta, concluding explicitly that the control of those costs "is a matter of vital public interest." 230 Kan. at 364-65. There is utterly no indication that this public interest has ceased to exist. If anything, it is more acute now than ever.

Courts have repeatedly found such provider agreements to be important tools of the vital public policy of limiting the growth of health care costs. Washington Hospital Center, 758 F.Supp. at 754 (noting that it was "easy to see how health costs" are

restrained under such a system). In Obstetrician-Gynecologis
361 N.W.2d at 556, the Nebraska Supreme Court noted Blue Cross
evidence that such a nonassignment clause was a "valuable tool"
holding down hospital costs, and concluded that the policy
allowing such clauses "indicates a far stronger public policy" th
the generalized support for free assignability.

The mere fact that there is not express authority for co
controls by mutual insurance companies should not be taken as
sign that the nonassignment clauses in the Blue Cross policies
not fulfill a public policy role. Thus, the court upheld the u
of such clauses in Obstetricians-Gynecologists as a reflection
the general policy of restraining health care costs, even thou
the court acknowledged that the statutory authorization for co
containment was much more general than that existing in Kansas
the time of Augusta. 361 N.W.2d at 556. The Delaware Supre
Court reached the same result in Kent, though again noting that th
policy favoring the cost restraint was only general in nature. 44
A.2d at 1372.

Finally, it is important to note the contradiction underlyin
the argument of St. Francis. St. Francis argues on the one han
that Blue Cross is no longer entitled to the public polic
balancing performed in Augusta since Blue Cross no longer enjoy
any special "mandate" for controlling health care costs unde
Article 18 of Chapter 40. Yet, on the other hand, St. Francis also
argues that the legislature's express decision via Chapter 195 t
allow Blue Cross to continue the use of nonassignment clauses is

invalid because it is special legislation. Far from serving as special legislation, Senate Bill No. 66, in fact, serves as a continuing expression of legislative concern for the rising cost of health care in Kansas. That is, just as the provisions in Article 18 were taken in Augusta as evidence of legislative intent to control costs, this is also the intent of Senate Bill No. 66.

Thus, the policy of free assignability is counterbalanced by freedom of contract. Nonassignment clauses, as used in the Blue Cross policies challenged herein, are valid and freely made contracts. Moreover, the validity of such clauses is also supported by the compelling public policy of controlling the growth of health care costs. This policy has been supported by both the state legislature and the courts. It is also reflected in Senate Bill No. 66 specifically. Thus, nonassignability is not a violation of public policy.

St. Francis's claims fail on the merits. And thus its request for injunctive relief also must fail, since a decision against it on the merits necessarily reflects a determination that St. Francis is not likely to win on the merits. Accordingly, the court finds that it is unnecessary to address ST. Francis's motion for a preliminary injunction.

IT IS ACCORDINGLY ORDERED this 30th day of December, 1992, that defendant Blue Cross's motion to dismiss (Dkt. No. 6) is hereby granted.

PATRICK F. KELLY, CHIEF JUDGE

Blue Cross
Blue Shield
of Kansas

1133 S.W. TOPEKA BOULEVARD • TOPEKA, KANSAS 66629-0001 • 913-291-8600

Thomas L. Miller
President and
Chief Executive Officer

TESTIMONY ON NON-ASSIGNMENT

February 15, 1993

Mr. Chairman and Members of the Financial Institutions and Insurance Committee, I am Tom Miller, President and CEO of Blue Cross and Blue Shield of Kansas. Thank you for providing me this opportunity to make a few comments as an opponent of HB 2096.

In an attempt to hold medical costs to a lower increase per year, Blue Cross and Blue Shield of Kansas offered a request for proposal from the three largest hospitals in Wichita this last summer. We intended to select two out of the three largest Wichita hospitals as contracting hospitals. The reason we sought only two of the three hospitals is because we were told by the hospitals that the only way we could get a better price is if we could bring a greater volume of patients to their hospital. The reason for going out for this bid was to try to obtain discounts that would hold down the rate increase that we must pass on to our insureds.

Unfortunately we received only one bid in response to our request for proposal. This bid came from the Wesley Medical Center. I should point out that this did result in our ability to reduce the 1993 rates for our insureds in Sedgwick county by 9% compared to what they would have been without this process. This will result in a savings of well over $13 million to our insureds statewide.

We recognize that Wesley, St. Joseph and St. Francis hospitals are all excellent hospitals. We were very disappointed that St. Joseph and St. Francis chose not to bid on our request for proposal. This meant that our only alternatives were to either take the one hospital bid or to continue to pay the hospitals at a much higher level in 1993.

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Underlying all of this activity was the fact that for the three previous years 1989, 1990, and 1991 our payout to the Wichita hospitals went up over 60% (more than 20% per year). During this same period of time, our enrollment was basically static. I know that some of the publicity coming out of Wichita says that our Blue Cross and Blue Shield of Kansas Board only allowed about a 5% increase in maximum allowable payments per year over this three year period. What this publicity failed to say, is (1) many Diagnosis Related Groups (DRG's), because of low frequency have no set maximum allowable payment and (2) the charges and numbers of out-patient services provided each year during this period of time increased dramatically and these increases were not included as part of the 5% allowance. The end result was over a 20% increase in payout per year. These are large omissions which represent the difference between the 5% maximum allowable payment increase per year for some in-patient DRG's and the actual payout of over 20% a year.

One of the criteria included in our request for proposal for the hospitals was the anti-assignment provision. What this means is that when an insured uses a hospital that is not contracting we make payment directly to our insured rather than to the hospital. This was one of the provisions contained in the request for proposal that enabled us to receive such an attractive bid from the Wesley Medical Center. We believe that the anti-assignment provision is needed in order to contain costs. This provision has resulted in lower prices for our insureds. Without the anti-assignment provision in our contracts, there would be virtually no reason for providers to contract with us since we would have to pay our allowance to the provider direct. The providers would then be free to balance bill our insureds instead of writing off balances. I should point out that our participating providers have written off over $50 million during 1992. This is a direct reduction in the amount of money that we must pay on behalf of our insureds resulting in lower rates charged.

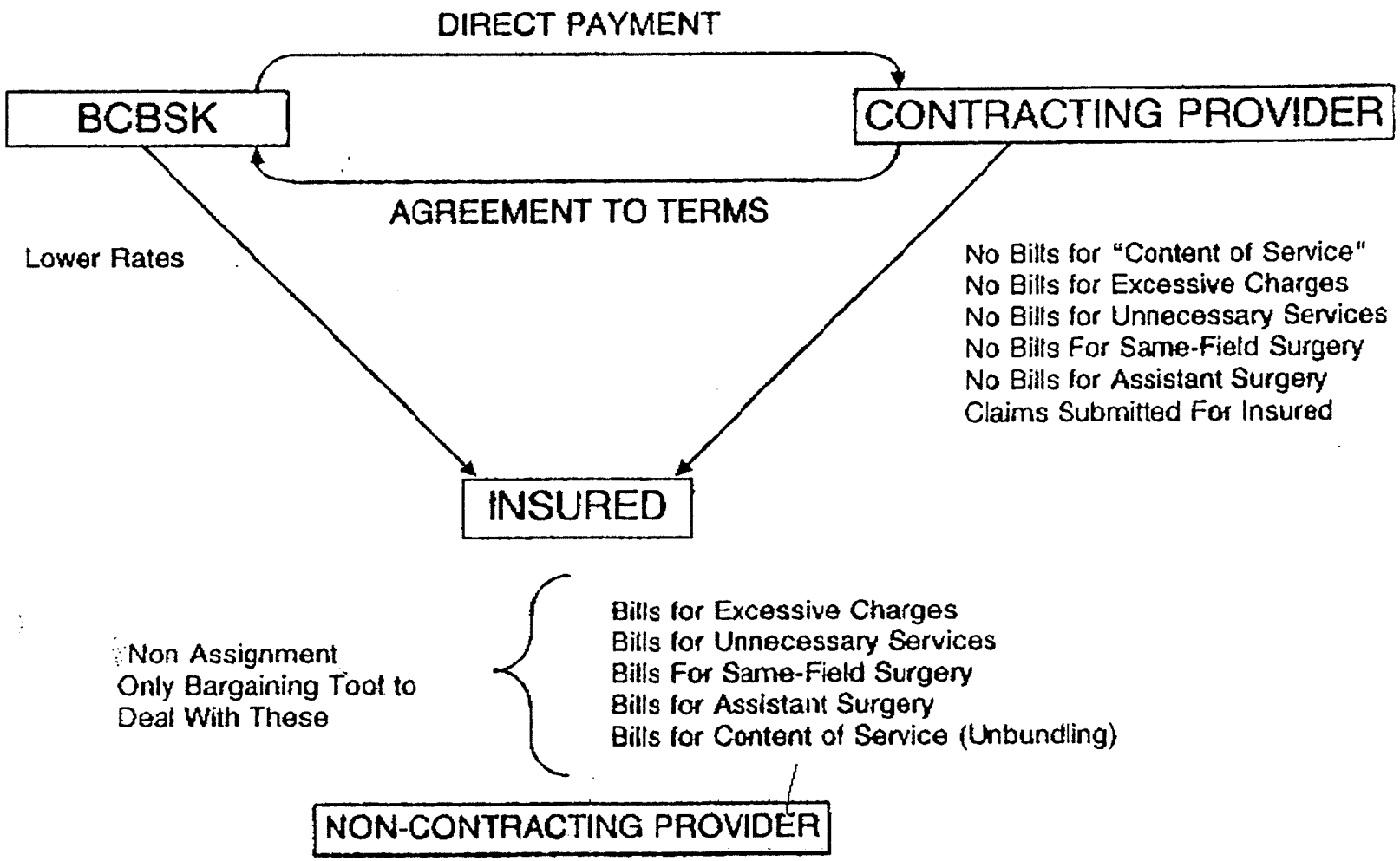
It seems that those providers who refused to participate in a competitive bid process now want to stop our contractual right to pay benefits directly to our insureds. It appears they want the privileges of contracting with Blue Cross and Blue Shield of Kansas but without the cost containment requirements.

Blue Cross and Blue Shield of Kansas has already spent thousands of our insureds dollars defending a lawsuit that was brought on by St. Francis Medical Center over this issue and a Federal Judge has already ruled that Blue Cross and Blue Shield of Kansas has a responsibility for cost containment on behalf of its insureds and that the anti-assignment provision is in the best interest of the people of Kansas. Now at least one provider who did not want to contract with us wants a law passed that would be contradictory to what a Federal Judge has already ruled.

Trying to get some control over health care costs is a national issue and we are trying to engage in cost containment activities that will slow the rate of inflation.

02/09/93

INSUREDS ARE BENEFICIARIES OF CONTRACTS BETWEEN BCBSK AND PROVIDERS



TESTIMONY ON KANSAS HOUSE BILL 2096
February 15, 1993

Rep. Bill Bryant, Chair

Western Resources

818 Kansas Avenue
P.O. Box 889
Topeka, Kansas 66601
Phone (913) 575-6300

My name is Collier W.Case. I am Manager, Employee Benefits for Western Resources. Western Resources is the largest electric and gas utility in the state, employing over 4050 Kansans.

Western Resources self insures the health care coverages for its active and many retired employees. As a business, and as a regulated utility, we are quite concerned with the rising costs of health care and legislation which inhibits initiatives to control costs.

We believe that House Bill 2096 takes the teeth out of laws, created by this legislature, which encouraged firms to set up contractual arrangements with health care providers. These contractual agreements may include discounts and scheduled write-offs which hold down the cost of health care for people using those providers and the companies and insurers who pay for many of those costs. House Bill 2096 strikes out one of the strongest leverage points in establishing these contractual arrangements, which is the provision that allows direct payment only to contracting health care providers. Without this provision, all providers, whether they have agreed to contract or not, would derive the same payment benefits from a timeliness and administrative cost standpoint. If you could get paid just as easily and quickly as your competitor

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without reducing your price and varying your service, why would you consider entering into a contract to do so? That is the essence of House Bill 2096. By having this provision in our laws, it provides a measure of incentive to the providers to enter into contracts and thus have a leg up on their competitors from the standpoint of faster reimbursement in exchange for their discounts and other considerations. This is a necessary condition for groups to expend the resources to establish contracting networks of providers.

As an employer who self insures its costs, we believe that managed care and use of contracting networks is vital for holding down the increases in health care costs. In our opinion, this legislature should be supporting efforts by willing groups of insurers and other health care networks to establish contracts with providers and allow them to be rewarded for their willingness to contract by the virtue of exclusive payment arrangements. House Bill 2096 flies in the face of past, <u>progressive</u> efforts in this area and sends the wrong message to the citizens, employers, health care networks and providers of health care services in this state. It says we are not supportive of health care cost containment and the efforts and concerns of those who desire to see progress in this area. In light of the nationwide, statewide and local call for health care reform, this Bill should not be passed.

Thank you for your time to hear our position in this matter.

ATE OF KANSAS

KANSAS STATE EMPLOYEES
HEALTH CARE COMMISSION

COMMISSIONERS:
Robert C. Harder, Ch
Ron Todd
Susan M. Seltsam

Dave Charay,
Benefits Administrator

M E M O R A N D U M

TO: Members of the House Financial Institutions and Insurance

FROM: Dave Charay, DC Health Benefits Administrator

DATE: February 15, 1993

SUBJECT: Testimony on HB 2096

Mr. Chairman, members of the Committee, thank you for the opportunity to present testimony in opposition to HB 2096. My name is Dave Charay. I am the Health Benefits Administrator for the Kansas State Employees Health Care Program. On behalf of the Kansas State Employees Health Care Commission, I am appearing today in opposition to HB 2096.

As introduced, HB 2096, would prohibit the non-assignability clauses of health providers which allows the provider to include provisions allowing for direct payment of benefits only to contracting health care providers. The effect of this bill would be that insurance carriers would have to pay hospital and physicians charges directly to non-participating physicians and hospitals. Passage of this bill would destroy the effectiveness of health insurance providers to control hospital and physician cost by taking their ability away to apply incentives or disincentives for providers to participate or unattractive not to participate.

Passage of this bill would make it difficult for Health Benefits Administration to negotiate health insurance contracts with health insurance providers that could have effective managed care arrangements with their physicians since the providers would have no leverage to apply incentives or disincentives for physicians and hospitals to participate in their network. Blue Cross and Blue Shield of Kansas (BC/BS), the State's health care provider for the past ten years would most likely have to increase their premium rates since BC/BS probably could not obtain the same physician and hospital discounts it now receives from its participating providers. Also, the number of hospitals and physicians presently participating in the State Blue Cross network would probably decrease.

JSD

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Landon State Office Building, Room 553-S., 900 S.W. Jackson, Topeka, Kansas 66612-1251, (913) 296-7483, fax (913) 296-2664

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Passage of this bill could have a major financial impact on the State's health plan. In 1991, claims utilization data indicates BC/BS participating providers wrote off more than $10.8 million in charges which exceeded BC/BS's allowances. In 1992, projected claims utilization data indicates BC/BS participating providers will write off at least $14.6 million.

The long range effect of this bill would be that the State of Kansas as well as State employees would most likely be paying higher premiums for health coverage. The inability by the State of Kansas to implement managed care programs would cause the State's health care cost to increase more rapidly than managed care programs. The number of physicians and hospitals willing to participate in managed care networks would 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 the allowable maximums.

Finally, passage of such a bill might not be a problem of managed care plans in urbanized states. In these states, the managed care plans can get providers to join the network by promising to direct more patients to the providers. However, in many areas of Kansas the insurer can not promise additional patients since there may only be one hospital and even possibly, one physician or pharmacy in the community. The only leverage BC/BS would have in such a situation is to promise to pay participating providers directly while paying benefits to plan members who use non-participating providers. Eliminating this option for BC/BS could cost Kansas citizens higher health insurance premiums in the future; therefore, we urge the committee to oppose HB 2096.

DC:bcl

cc: R. Harder
J. Rickerson
R. Roberts
S. Seltsam
R. Todd

HMO KANSAS, INC.
A Subsidiary of
Blue Cross and Blue Shield of Kansas, Inc.

P.O. BOX 110
TOPEKA, KS
66601-0110

SUMMARY OF CLAIM PROCESSED

THIS IS NOT A BILL

PH00002169

1 DATE OF SERVICE	2 TYPE SER-VICE	3 PLACE OF SERVICE	4 TOTAL CHARGES	5 NON COVERED SERVICES	6 OTHER INSURANCE PAYMENT	7 APPLIED TO DEDUCTIBLE	8 MEMBERS SHARE (CO-INSURANCE)	9 YOUR RESPONSI-BILITY	10 PROVIDER WRITE OFF	11 AMOUNT PAID	12 SEE NOTE BELOW	13 DATE CLAIM RECEIVED	14 DATE CLAIM PROCESSED	15 PAID TO
CLAIMS PROCESSED FOR:														
SERVICES PROVIDED BY HCA						WESLEY ME								
01/07/93	6	IP	867040	1500		5000		6500	301964	558576	S	01/19/93	01/21/93	PROVIDER
SERVICES PROVIDED BY WICHITA						RAD GROUP								
01/06/93	12	OP	2800						575	2225	S	01/18/93	01/22/93	PROVIDER
01/07/93	12	IP	7600						1125	6475	S	01/18/93	01/22/93	PROVIDER
SERVICES PROVIDED BY OHAEBOSIM						MEDICAL								
01/12/93	7	OFFICE	2000						1000	1000	S	01/15/93	01/21/93	PROVIDER
01/12/93	6	OFFICE	2500			1000		1000		1500		01/15/93	01/21/93	PROVIDER
01/06/93	6	OFFICE	2500			1000		1000		1500		01/15/93	01/21/93	PROVIDER
12/30/92	6	OFFICE	2500						50	2450	S	01/15/93	01/21/93	PROVIDER
SERVICES PROVIDED BY EMER						SERV								
01/07/93	6	IP	22950						14425	8525	S	01/19/93	01/22/93	PROVIDER
SERVICES PROVIDED BY WICHITA						RAD GROUP								
01/07/93	12	IP	7400							7400		01/18/93	01/22/93	PROVIDER
SERVICES PROVIDED BY HCA						WESLEY CAR								

NOTE S – YOUR CONTRACTING PROVIDER HAS AGREED TO ACCEPT OUR ALLOWED CHARGE AND SHOULD NOT BILL YOU FOR THE AMOUNT IN COLUMN 10. IF THE PROVIDER BILLS YOU FOR THE AMOUNT IN COLUMN 10, PLEASE CONTACT US.

Type Service (column 2)

1. Dental	7. Prescription Drugs	12. Radiology Prof. Component
2. Surgery	8. Durable Medical Equip.	13. Radiology Tech. Component
3. Maternity	9. Laboratory	14. Accident Hospital Services
4. Anesthesia	10. Laboratory Prof. Component	15. Other
5. Asst. Surgery	11. Radiology	16. Plan 65
6. Medical Care		

Member Name _____ Identification # _____

Group Name STATE OF KS ACTIVE-CAP Group # _____

THIS IS NOT A BILL - PLEASE KEEP FOR INCOME TAX PURPOSES

TO REPORT SUSPECTED FRAUD CONTACT SPECIAL INVESTIGATIONS - 1-800-432-0216

PLEASE SEE REVERSE FOR APPEAL PROCEDURE

84-88 (1/92)

HMO KANSAS, INC.
A Subsidiary of
Blue Cross and Blue Shield of Kansas, Inc.

P.O. BOX 110
TOPEKA, KS
66601-0110

SUMMARY OF CLAIM PROCESSED

THIS IS NOT A BILL

PH00002170

1 DATE OF SERVICE	2 TYPE SER-VICE	3 PLACE OF SERVICE	4 TOTAL CHARGES	5 NON COVERED SERVICES	6 OTHER INSURANCE PAYMENT	7 APPLIED TO DEDUCTIBLE	8 MEMBERS SHARE (CO-INSURANCE)	9 YOUR RESPONSI-BILITY	10 PROVIDER WRITE OFF	11 AMOUNT PAID	12 SEE NOTE BELOW	13 DATE CLAIM RECEIVED	14 DATE CLAIM PROCESSED	15 PAID TO
01/07/93	9	IP	1850							1850		01/19/93	01/22/93	PROVIDER
TOTAL THESE SERVICES			919140	1500		7000		8500	319139	591501				

Type Service (column 2)

1. Dental	7. Prescription Drugs	12. Radiology Prof. Component
2. Surgery	8. Durable Medical Equip.	13. Radiology Tech. Component
3. Maternity	9. Laboratory	14. Accident Hospital Services
4. Anesthesia	10. Laboratory Prof. Component	15. Other
5. Asst. Surgery	11. Radiology	16. Plan 65
6. Medical Care		

Member Name _____ Identification # _____

Group Name STATE OF KS ACTIVE-CAP Group # H.

THIS IS NOT A BILL - PLEASE KEEP FOR INCOME TAX PURPOSES

TO REPORT SUSPECTED FRAUD CONTACT SPECIAL INVESTIGATIONS - 1-800-432-0216

PLEASE SEE REVERSE FOR APPEAL PROCEDURE

84-88 (1/92)

KANSAS ASSOCIATION OF REALTORS®

Executive Offices:
3644 S. W. Burlingame Road
Topeka, Kansas 66611
Telephone 913/267-3610

TO: THE HOUSE COMMERCIAL AND FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

FROM: JIM MAYER, EXECUTIVE VICE PRESIDENT

DATE: FEBRUARY 15, 1993

SUBJECT: HB 2096 - DIRECT PAYMENT OF BENEFITS TO CONTRACTING HEALTH CARE PROVIDERS

Thank you for the opportunity to testify. On behalf of the Kansas Association of REALTORS®, I appear today to oppose HB 2096.

Our association has between 1,500 and 2,000 members that are Blue Cross/Blue Shield policy holders through the KAR group plan. We have an additional one thousand or more that are policy holders of Blue Cross/Blue Shield through individual and other group plans.

We oppose this bill for several reasons. Blue Cross/Blue Shield's ability to refuse assignments of insurance unless they have contracted with the provider has saved our members and many other citizens of Kansas hundreds of thousands of dollars over the years.

Blue Cross/Blue Shield of Kansas' ability to negotiate the costs of health care with providers has curtailed, somewhat, the outrageous cost of health care to our members.

I personally can attest to the fact of such savings. I had a series of major and expensive surgeries. Because the surgeon was a contract provider and because the hospital was a contract provider:

1. I did not have to prove my financial ability to pay prior to entering the hospital.

2. The provider write off amounted to several thousand dollars for which the provider could not later bill me.

3. I did not have to fill out tons of paper work, pay up front and wait for reimbursement from an insurance carrier.

4. The group did not have a major increase in policy premiums because of prior negotiated contracts and provider write off by Blue Cross/Blue Shield.

At this time the number one concern of this nation is providing affordable health care for all ages of our citizens. The last thing we need are laws that add another layer of costs for such care.

-continued-

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If this bill should become law it would cost several thousand of our members, including myself, thousands of dollars for increased insurance premiums and additional health care costs, plus time and energy filling out the paper work.

We would respectfully ask that you do not pass HB 2096 favorably. I thank you for the opportunity to testify and I would stand for any questions.

2096

HOUSE FINANCE INSTITUTIONS AND INSURANCE COMMITTEE

HOUSE BILL 2096 TESTIMONY

February 15, 1993

Jim Biltz
President and Chief Executive Officer

HCA Wesley Medical Center
Wichita, Kansas

On behalf of HCA Wesley Medical Center, I am speaking in opposition to House Bill 2096. The assignment issue is a cost containment provision which is of significant importance to HCA Wesley Medical Center as it relates to our Blue Cross contract. When we bid for the Blue Cross contract, the assignment provision was of significant value to ensure patient volume. Our discount and the savings to the Blue Cross patients are dependent upon Blue Cross's ability to retain the assignment provision. Your passage of House Bill 2096 will create a barrier to the process of health care cost containment and have a costly impact for Wichita and elsewhere in the State.

FI&I
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2-15-93

PLUMBING AND PIPEFITTING INDUSTRY HEALTH AND WELFARE FUND OF KANSAS

505 S. Broadway, Suite 117
Wichita, Kansas 67202-3922

Phone (316) 264-2339
Fax (316) 264-9245

JOE D. PUCCI, Administrator

February 15, 1993

Kansas House of Representatives
Commercial and Financial
Institutions and Insurance Committee

Re: HB 2096

Dear Committee Member:

I should begin by introducing myself and my organization. I am the Administrator of a "Taft-Hartley Trust Fund". The Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas provides health care benefits for the members of the five Pipefitter Local Unions in the state of Kansas. Currently the Plan has over 2,500 Participants. The Trust is governed by an equal number of Management and Labor Trustees.

I am also a member of the Kansas Commission on the Future of Health Care (403 Commission). Naturally, as a Fund Administrator and as a Commissioner, I am very concerned about cost containment.

The Group I represent is self-funded, we do not pay premiums to an insurance company. The claims of our members are paid from the contributions the Fund receives from 126 Kansas Employers. Blue Cross Blue Shield of Kansas (BCBS) performs administrative services for our Group and we utilize the BCBS Network of Providers. HB 2096 would remove one provision of the law that my group relies on to achieve cost containment. Namely, the deletion of:

"The agreements issued by any corporation currently or previously organized under this act may include provisions allowing for direct payment of benefits only to contracting health care providers."

I know its difficult to grasp how the removal of this language would harm us. Certainly the concept of providing direct payment to all hospitals seems fair. To understand why we are opposed to this change, you really must understand why we negotiate agreements with certain hospitals. If an insurance company or a health plan approaches a hospital and asks for discounts, they must be able to offer something in return. Usually, what we offer is a volume of patients and direct payments to the hospital. These arrangements are very beneficial to our members because a contracting hospital agrees to accept the allowable payment as payment in full. The hospital cannot bill our members for charges in excess of what we have agreed to pay. Obviously, the direct payment of benefits eliminates the hospitals credit risk.

If we can refuse assignment, a provider does have something to lose by not signing a contract. By using the lever of assignment of benefits, BCBS has reduced the cost of care for my members. The anti-assignment provision of the law is a fair negotiating tool.

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Let's get to the heart of this matter. HB 2096 is a direct result of judge Kelly's decision that Senate Bill 66 was not unconstitutional and was a cost containment measure. St. Francis Regional Medical Center of Wichita made a business decision to not bid the new BCBS Contract. By their own calculation, St. Francis stood to increase their net income by over 3 million dollars if they did not sign a contract with BCBS.

Why? Because St. Francis would receive from BCBS more than they would normally receive from their own PPO for the same services and they could then bill my members for any excess charges. They could shift the cost of their discounts to us. In other words why buy the cow if the milks free.

What they failed to consider was BCBS's utilization of the anti-assignment clause. Now they want to change the rules!

St. Francis is owned by the same corporation that owns Preferred Health Care (PHC). PHC is a Preferred Provider Organization (a PPO is a Network of Providers). What we're really observing is a war between BCBS and PHC over control of the Wichita Provider Network. If PHC successfully drives BCBS out of Wichita, we will have a hospital negotiating with itself to set payment levels for itself. That makes me very nervous.

So what portion of Senate Bill 66 does St. Francis find unpalatable? St. Francis objects to the affirmed right of BCBS to refuse an assignment of benefits on our behalf.

The end result of HB 2096 will be higher premiums and higher costs. Who will pay these costs? One way or another my members will. Either out of their own pockets or thru reduced wages because of the increasing cost of providing them with health care.

Its important that you realize, I am not concerned about the well-being of BCBS or any other insurance company. My bottom line is the members of our Group. If HB 2096 becomes law, the legislature will be adding to the already overwhelming burden, health care costs have placed on the Kansas consumer.

I thank you for your consideration.

Sincerely yours,

Joe Pucci

Joe D. Pucci
Administrator for the Trustees

2-7-13

AIA Kansas
A Chapter of The American Institute of Architects

Mr. Chairman and Members of the Committee:

I am Trudy Aron, Executive Director of the American Institute of Architects in Kansas. Thank you for allowing me to testify in opposition to HB 2096.

I am not an expert on insurance or health care costs nor are our members experts in this area. But I know that health care costs continue to go up and our insurance premiums continue to increase at annual rates significantly higher than any other cost of doing business. Our members are small businesses, over 95% of our members practice in firms with less than ten employees. Health insurance is fast becoming a benefit some firms can no longer provide to their employees.

Just as businesses search out the most economical supplies and equipment, insurance companies must be allowed, through contracts and assignment of benefits, to search out those providers who offer the most economical yet dependable medical services.

We believe passage of HB 2096 will continue to allow hospitals and other health care providers to escalate their prices without establishing cost cutting measures. We urge you to help consumers by opposing the passage of HB 2096.

I will be happy to answer any questions you may have.

700 SW Jackson, Suite 209
Topeka, Kansas 66603-3757
Telephone: 913-357-5308
800-444-9853
Facsimile: 913-357-6450

H.D.I
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Attachment 13

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Testimony to House Financial Institutions and Insurance Committee

on HB 2096

(Prohibits health insurers from making direct payments only to contracting providers)

by James P. Schwartz Jr.
Consulting Director
February 15, 1993

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is 110 employers across Kansas who share concerns about the cost of health care for our 350,000 Kansas employees and dependents.

Managed competition appears to be the approach this country will take to deal with the soaring cost of health insurance. That approach involves contractual arrangements between health plans, providers and patients, with incentives for efficiency by all three.

As managed care continues to evolve and competition heats up, a disturbing tendency has emerged, not among contracting parties, but among *non*-contracting groups. The tendency has been for those groups to seek legislation to diminish the difference between contracting and not.

If managed competition is to have a chance of working, contracts must be allowed to exercise their incentives. It may be that assignment of benefits is not the most effective or user-friendly incentive for inducing efficient behavior, but if not, the market will tell soon enough. We feel it's important to allow health-insurance contracts to experiment and for government to intercede only when patient health is clearly jeopardized.

I & I
2-15-93

Attachment 1-4

STATE OF KANSAS

KANSAS
INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612-1678 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

RON TODD
Commissioner

M E M O R A N D U M

TO: The Honorable Richard L. Bond, Chair
Senate Committee on Financial Institutions and Insurance

FROM: Dick Brock, Administrative Assistant
Kansas Insurance Department

SUBJECT: 1991 Senate Bill No. 66

DATE: April 7, 1992

I'm not sure I know why Senate Bill 66 is in conference committee. I assume it's because the technical amendment made by the House to reflect current provisions of K.S.A. 40-2209 is so lengthy. In any event, the fact it is in conference gives us the opportunity to suggest consideration of two other amendments that would be helpful in clarifying existing statutory provisions.

The first suggestion relates to the provisions of 1991 House Bill 2001 which requires Kansas Blue Cross and Blue Shield to convert to a mutual insurance company by July 1, 1992. During legislative consideration of this matter, it seemed to clearly be the legislative intent as well as the intent of this Department and the organization directly affected that such conversion should not require Kansas Blue Cross and Blue Shield to change their operations or style of doing business. However, as we have moved forward in the conversion process, we have encountered a significant contractual matter that may be lost in the transition.

Specifically, the laws under which Blue Cross and Blue Shield plans were organized and still operate contain specific and unique cost control requirements to which Blue Cross and Blue Shield plans must adhere. These requirements apply to both internal administrative costs as well as costs charged to the plans by participating hospitals and physicians. These provisions are particularly significant in view of Augusta Medical Complex v. Blue Cross and Blue Shield of Kansas which held that, because of these statutory cost control requirements, it is permissible for Blue Cross and Blue Shield plans to refuse to pay subscriber benefits directly to a nonparticipating (non-contracting) provider. This is a very significant consideration because it is obvious that the sponsor of any preferred provider or managed care arrangement must have some ability to apply incentives or disincentives that both encourage consumers to utilize the controlled cost environment and either make it attractive for

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Attachment 15

providers to participate or unattractive if they do not do so. However, these cost control requirements are not included in the statutes governing mutual insurance companies. Therefore, there is a serious question as to whether the case law established by the Augusta case would still apply. To remove this question, I have attached a balloon amendment to line 16, page 2 of the bill which I hope the conference committee will consider.

The second suggestion involves a technical "clean-up" of 1991 House Bill 2001. As you will recall, when the substantive provisions of this bill were agreed to, it was amended to apply to all relevant insuring entities in order to establish a level competitive environment. In doing so, all subsections of K.S.A. 40-2209 were applied to health maintenance organizations. This included 40-2209(D) which contains continuation and conversion requirements to accommodate persons terminated from group coverage. This creates a conflict because HMO's are subject to specific conversion requirements that recognize the territorial restrictions which are an integral part of the HMO structure. Therefore, to remove this conflict, the attached balloon also includes an appropriate amendment that would appear as a "new" section 3 as well as the resultant changes in the title and the repealer section.

DB:mmk

Attachment

cc: The Honorable Alicia Salisbury
The Honorable John Strick
The Honorable Larry Turnquist
The Honorable Galen Weiland
The Honorable Melvin Neufeld

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1504
(913) 296-2436
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Joan Finney
Governor

Gloria M. Timmer
Director

February 12, 1993

The Honorable William Bryant, Chairperson
Committee on Financial Institutions and Insurance
Statehouse, Room 112-S
Topeka, Kansas 66612

Dear Representative Bryant:

SUBJECT: Fiscal Note for HB 2096 by House Committee on Financial Institutions and Insurance

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2096 is respectfully submitted to your committee.

HB 2096, as introduced, would delete language in the statute that currently allows any corporation currently or previously organized under KSA 40-19c06 to make direct payment of benefits only to contracting health care providers. The bill would not allow such corporations to refuse to pay the charges of health care providers not under contract, meaning that direct payment of benefits also would have to be made to non-contracting providers. The only corporation affected by this bill is Blue Cross and Blue Shield of Kansas.

HB 2096 would have a fiscal impact on state government, local governments, and the private sector. Although information was available only on the impact to the state and some local governments, many private sector organizations are increasingly using managed care contracts to provide health care to their employees and would likely experience increased costs as a result of HB 2096. Such cost increases would probably result in increases in premiums paid by employees. The following fiscal note describes the impact on state and local governments.

F D S

2-15-93

Attachment 16

Impact on Health Insurance Costs for State Employees

The fiscal effect of HB 2096, as introduced, for FY 1994 would increase expenditures from the State General Fund by approximately $7.7 million and expenditures from all funding sources by approximately $16.0 million above the amounts included in the *FY 1994 Governor's Budget Report*. The effect in FY 1995 would be approximately $8.6 million from the State General Fund and $18.0 million from all funding sources.

The above estimates are based on claims utilization data from Blue Cross and Blue Shield of Kansas that indicate its participating providers in 1992 wrote off approximately $14.6 million. In 1991, $10.8 million in charges which exceeded Blue Cross's allowances were written off. It is anticipated that with the hospital contracts signed in Wichita, Blue Cross will increase its claims utilization savings in 1993. HB 2096 would require that amounts currently being written off would have to be paid, which means that the State would have to pay more for its contract to insure state employees.

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. (Since 1990, the cost of health insurance for state employees has risen an average of 12 percent each year.) 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.

Impact on Local Units of Government

Because many local units of government contract with Blue Cross and Blue Shield of Kansas for employee health care, significant fiscal impact from HB 2096 is anticipated. Counties, cities, and school districts across the state could experience higher health care costs in the form of increased premiums and copayments by employees. The following table shows a few of the affected jurisdictions and the estimated annual increase in health care costs expected from HB 2096.

Table 1: Estimated Increase in Employee Health Care Costs in FY 1994 Caused by HB 2096.

Jurisdiction	Rate	Amount
Sedgwick County	16.8%	$876,264
Shawnee County	19.4	222,654
Saline County	14.6	84,006
City of Wichita	16.6	812,712
City of Topeka	19.6	748,209
City of Salina	12.7	111,945
City of Lawrence	9.3	126,996
USD 501 - Topeka	17.1	642,282
USD 259 - Wichita	15.9	2,433,321
USD 497 - Lawrence	5.8	117,389
USD 253 - Emporia	9.1	44,771

The above jurisdictions are examples of some of the local units of government that could experience a fiscal impact from HB 2096. The amounts are estimates compiled by the Division of the Budget based on data from 1991 and 1992 provided by Blue Cross.

Impact on State Premium Tax Revenue

The bill would likely increase the cost of health insurance provided by Blue Cross to many of its 670,000 clients in Kansas. Any increase in rates would likely increase the amount of premium tax collected and deposited into the State General Fund. Unfortunately, no reliable method exists for determining the amount of any such increase in state premium tax collections.

Impact on State Operating Budgets

HB 2096 would require Blue Cross and Blue Shield of Kansas to file revised policy forms and possibly rates with the Insurance Department to reflect the acceptance of an assignment of benefits. This additional workload would be absorbed by existing personnel and would not otherwise affect the department's operating budget. In addition, no impact is anticipated on the operating budget of the Health Benefits Administration.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Dave Charay, Health Care Commission
Dick Brock, Insurance Department

3/16