Approved: February 22, 1993
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Richard Bond at 9:17 a.m. on February 19, 1993 in Room 529-S of the Capitol.

Members present: Senators Corbin, Hensley, Lee, Petty, Praeger, and Steffes.

Committee staff present: William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
June Kossover, Committee Secretary

Conferees appearing before the committee: Manya Schmidt, ARNP, CNM
Linda Sebastian, ARNP, CNS
Abby Horak, KDHE
Ralph Weber, MD, Blue Cross/Blue Shield

Others attending: See attached list

Senator Corbin made a motion, seconded by Senator Steffes, to approve the minutes of the meeting of February 18, 1993 as submitted. The motion carried.

The continued hearing on **SB 187**, reimbursement for services of advanced nurse practitioners, was opened. Manya Schmidt, ARNP, CNM, appeared as a proponent of this legislation. (Attachment #1.)

Linda Sebastian, ARNP, CNS, provided copies of the impact study on this legislation. (Attachment #2.) Ms. Sebastian advised the committee that as many resources as possible were used and Dick Brock, Insurance Department, assisted the KSNA with the study. In response to Senator Steffes' question, Ms. Sebastian explained how the figure of $293,834 projected additional reimbursement by BC/BS was arrived at. Senator Petty requested clarification on the figure of 90% of ARNP's already being reimbursed by BC/BS and Ms. Sebastian responded that they are being paid under the physician's provider number. Senator Praeger asked if the current billing practice would continue if nurse practitioners could bill and be paid under their provider numbers. Ms. Sebastian responded that a very few physicians might elect to continue the current billing practice. In response to Senator Bond's question about whether doctors would reduce their charges, Ms. Sebastian answered that physicians would not be charging if nurse practitioners delivered the service and were allowed to bill separately. Senator Corbin expressed concern that nurse practitioners would remove from the physicians' office and set up separate practices. In response to Senator Petty, Ms. Sebastian advised that nurse practitioners have definite boundaries to their practice and do not duplicate physician services and there would be no need for physicians to duplicate nurse practitioner services.

Abby Horak, KDHE, appeared to answer any questions pertaining to the testimony of Joyce Volmut, which was heard in the meeting of February 11. Senator Steffes voiced his concern that this bill would encourage nurse practitioners to leave the rural areas for urban areas, thereby defeating the purpose of the original legislation. Ms. Horak responded that surveys do not indicate that this is likely to occur.

Written testimony in favor of this legislation was submitted by Susan Alexander, RN, BSN. (Attachment #3.)

Ralph Weber, MD, appeared as an opponent of **SB 187.** (Attachment #4.) Dr. Weber clarified for Senator Lee the basis for Blue Cross/Blue Shield's belief that this legislation will cause an increase in provider costs and, as a result, an increase in premiums to subscribers.

Due to the length of today's meeting, the remaining conferee was not heard; therefore, the hearing on **SB 187** was continued to Monday, February 22, 1993.

The committee adjourned at 9:58 a.m.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE DATE: 2/19/93

NAME	ADDRESS	ORGANIZATION
Rebecca Ole	8000 SW 23	KSNA
Patti L. Gallimore	Fairview 7/8	KSNA
Conda Byrne	3221 SW Atwood Topeka	KSNA
Rosie Valiquria	3624 SW Red Hawk Topeka	KSNA
Linda Sebastian	Topeka	KSNA
Mary P. Schmidt	Topeka	KSNA
Pamela Byl	Topeka	KSNA
Donald R. Streeter	RR#2 Box 42 Mayetta Ks 66509	KSNA
Susan Alexander	Box 245 Strong City, KS	FNPS - Ft. Hays
Charles Walker	Topeka	DMS - SRS
Bill Sneed	Topeka	NIAA
RH Weber MD	Topeka	BCBS
Chip Wheeler	Topeka	Ks Medical Soc.
Jerri Roberts	Topeka	KSNA

February 11, 1993

SB 187

Chairman Bond and members of the Senate Financial Institutions and Insurance Committee, my name is Manya Schmidt ARNP, CNM I am a certified nurse midwife and a family nurse practitioner. I completed the University of Kansas Primary Care Nurse Practitioner Program in Hays in July of 1984. I most recently completed the Community Based Nurse Midwifery Education Program, a joint program of the Frontier School of Midwifery and Family Nursing and Case Western Reserve University (Cleveland, Ohio). I currently work as a Nurse Midwife and Nurse Practitioner in a variety of settings providing care to women and infants.

I am here in support of SB 187 and to give you an ideas of the kind of services that I provide to clients in the Topeka area. The majority of my time is in the delivery of primary and obstetrical care for clients seeking services at the Holistic Birth and Growth Center. This is the only freestanding birth center in the state of Kansas, which is fully accredited by the Commission for the Accreditation of Freestanding Birth Centers and also licensed by the state of Kansas. We have 100-120 births per year. There are two other nurse midwives at the birth center working collaboration with one physician. We are the only nurse midwives in the state providing full scope nurse midwifery services. This includes, prenatal, labor and delivery, postpartum and well-woman gyne-

Senate 7/41
2/19/93
Attachment #1

cologic services. Currently our charge for the total care provi during pregnancy is $3600, which is approximately $900 less than the two local hospitals and the prevailing physician fee. 25% of our clients are self-pay. 25% are commercial insurance and the remaining 50% are under a managed care program.

Another group of women that I see include women receiving services through the Topeka Shawnee County Health Department's Maternal and Infant Project. Many of these women are Medicaid recipients, who do not have access to care in the private sector and rely solely on the clinic for prenatal care services. There are also non-Medicaid eligible pregnant women who rely on this service for purely financial reasons. The services that I have described to you are services covered in all health insurance plans, except, those excluding maternity benefits. As a recognized and licensed certified nurse midwife I believe that my services should be reimbursed directly. Such billing practices would be more reflective of care provided by ARNP's and would not increase the cost of services. Additionally, one of the challenges facing nurse midwives in Kansas is obtaining hospital privileges for normal deliveries. I recognize that this committee is dealing strictly with the insurance aspect of our care delivery, however, I wanted you to know the limitations placed on our practice at this time.

Thank you for the opportunity to speak to you today. I would be happy to provide any further information you might like.

4+1 2/19/93

1-2

Third Party Reimbursement for Nurses in Advanced Practice

An Access Alternative Without Sacrificing Quality

IMPACT REPORT FOR Senate Bill 187

Prepared by the Kansas State Nurses Association February 1993

KSNA

the voice of Nursing in Kansas

Senate 7/+1
2/19/93 Attachment #2

HISTORICAL BACKGROUND

The Kansas State Nurses' Association, representing registered nurses in advanced practice, is sponsoring legislation that would require health insurers in Kansas to reimburse Advanced Registered Nurse Practitioners (ARNP) in 6 urban counties for services that are currently within policies as covered services, but only physicians or other providers are reimbursed directly. In 1990 a provision was passed that provided coverage for ARNP's in all but six Kansas counties: Wyandotte, Johnson, Leavenworth, Douglas, Shawnee and Sedgwick.

The proposed legislation would add Advanced Registered Nurse Practitioners (ARNP's) to the list of providers already eligible for third party reimbursement in the other 99 counties. There are four categories of ARNP's recognized in Kansas by the Board of Nursing: Clinical Nurse Specialist, Nurse Practitioners, Nurse Midwives and Nurse Anesthetists. This bill would give subscribers to health insurance in Wyandotte, Johnson, Leavenworth, Douglas, Shawnee and Sedgwick counties, the freedom to choose an ARNP as a provider of their health care services and have these services paid for by insurance regardless of where the service is delivered.

The proposed legislation would eliminate discriminatory practices present under current insurance laws which allow for reimbursement to some qualified health care providers, but not to others equally qualified to provide these services.

This impact report is being submitted in compliance with KSA 40-2248 (H.B. 2888, 1990) and will focus on the six urban counties.

Note: This report will not include reference to or data about one group of ARNP's, the nurse anesthetists. This group has been reimbursed by Blue Cross Blue Shield (BCBS) in all counties, including urban since 1980 when agreement was reached between the nurse anesthetists and BCBS.

414 2/19/93

Impact Report

REQUIREMENT: The social impact, including: The extent to which the treatment or service is generally utilized by a significant portion of the population.

Treatment and services by ARNP's include a variety of services and populations. The categories of ARNP's (excluding nurse anesthetists) are:

Nurse Practitioners
Clinical Nurse Specialists
- pediatric
- maternal-child
- psychiatric
- medical-surgical

Nurse Midwives

The Kansas State Board of Nursing regulates ARNP's pursuant to K.S.A. 65-1130 and the types of services provided by each category of ARNP are listed below:

Nurse Practitioners (NP's)

Working in clinics, nursing homes, hospitals, or their own offices, NPs are qualified to handle a wide range of basic health problems. Most have a specialty--for example, adult, family, or pediatric health care. NP's conduct physical exams, take medical histories, diagnose and treat common acute minor illness or injuries, order and interpret lab tests and X-rays, and counsel and educate clients. In at least 35 states, they may prescribe medication. Some work as independent practitioners and can be reimbursed by Medicare or Medicaid for services rendered; others work for hospitals, HMO's, or private industry.

Clinical Nurse Specialists (CNS's)

Besides delivering direct patient care, CNS's work in a variety of consultative, research, education, or administrative roles. They provide primary care and psychotherapy, develop nursing care techniques and quality control methods, teach nurses and other health care professionals, and act as clinical consultants.

Certified Nurse Midwife (CNM)

CNM's provide prenatal and gynecological care, deliver babies in the home, hospital, or birthing center, and follow mothers post-partum. In 1988, CNM's delivered 115,000 babies in hospitals, or about 3.4 percent of all U.S. births that year. The Office of Technology Assessment in a widely cited 1986 study found that CNM's manage normal pregnancy safely and as well as or better than MD's, achieved lower rates of low birth-weight infants, and had shorter inpatient stays for labor and delivery than similar patients of obstetricians.

REQUIREMENT: The social impact, including: The extent to which such insurance coverage is already generally available.

Insurance coverage for ARNP's in Kansas currently available includes:

- federal Medicare
- CHAMPUS
- state Medicaid
- self-insured plans
- commercial insurance with the exception of BCBS (Kansas City and Kansas), which recognizes the six-county exclusion. From the data currently available, no other commercial payor recognizes the six-county exclusion.

REQUIREMENT: The social impact, including: If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment.

7141 2/19/93 2-3

L coverage by BCBS which is approximately 37% of the Kansas commercial payor market in these counties h: lted in:

A perception on the part of ARNP's and physicians that all reimbursement is denied. This has caused many physicians and ARNP's to not pursue collaborative practice.

A disproportionate case mix that exphasizes only uninsured, medicare/medicaid clients which decreases the financial viability of an ARNP's practice, regardless of the area of practice.

The burden of double-payment by patients who have paid BCBS premiums and whose policy might cover the services of an ARNP but insurance payment is withheld because of the geographical location of the ARNP's practice.

Access to needed services, such as primary care, maternity care, pediatric and geriatric services have been lessened due to the lack of available health care providers in our state. Available Kansas data indicates the following:

In 1992 the indigent clinics in the six most populated counties in Kansas provided medical services through provision of care in over 70,000 patient visits. The greatest number of patients seen in each clinic was above the age of 20 years, with clinics reporting between 13% and 37% of those seen under the age of 19 years. The majority of these clients had no form of reimbursement for their health care services (however between .7% and 2% of the patients are reported to have insurance in three of the clinics). As many as 44% may have Medicaid coverage with approximately 5% showing Medicare coverage.

According to results of "Project Eagle" there is a concern for the high percentage of family members in the 120 families included in their study, who make too much money for state funded medical care and too little for private insurance. These family members are not able to access health care.

Shawnee County has a serious shortage of primary care physicians. The Topeka-Shawnee County Health Agency is the only source of care for new Medicaid recipients and for Medicare recipients who are not already established with a private physician. In February 1992, there were no pediatricians, family practitioners or obstetricians accepting new private Medicaid patients in Shawnee County.

Currently, in Shawnee County only five Family Practice physicians are accepting patients in the Medicaid primary care network program (PCN). Approximately 2500 patients remain unassigned each month. Currently in Shawnee County only two family practice physicians are taking new Medicare patients.

In Sedgwick County approximately 5000 clients remain unassigned each month. About 2500 of these clients remain unassigned even after 120 days.

In Wyandotte County, the number of unassigned patients is approximately 2500 each month.

Of the six counties, according to the 1991 Kansas Federally Designated Medically Underserved Areas Report, three are considered partially underserved (Wyandotte, Shawnee, Sedgwick).

The following census tracts per county are federally designated as underserved:

Designated Service Area	County	Designated Service Area	County
Chetopa City	Sedgwick	Nevada Township	Wyandotte
Elm Grove Township		Almena Township	
Oswego City		Natoma Township	
Elkhorn Township		Ross Township	
Pleasant Township		Miami Township	
Marquette Township		Sylvia Township	
Florence City		Richland Township	
Fowler Township		Scandia Township	
Osage Township		Sterling City	
		Union Township	
Osawatomie City	Shawnee	Victoria Township	
Paola City		Bala Township	
		Fairview Township	
		Smoky Hill Township	
		Smolan Township	

4141 2/19/93
2-4

I IREMENT: The social impact, including: If the coverage is not generally available, the (; to which the lack of coverage results in unreasonable financial hardship on those persons ... ding treatment.

The lack of coverage has caused ARNP's to avoid the urban areas. This is one factor in the lack of enough primary care providers. Even for those patients whose insurance company will pay for the services of an ARNP, there are not enough ARNP providers. For those with BCBS, this
results in double payment--the insurance premium and the payment for the
service provided by an "ineligible" provider.

REQUIREMENT: The social impact, including: The level of public demand for the treatment or service.

The public is generally not knowledgeable about ARNP's. The reliance on a physician-dominated health care delivery system has resulted in a lack of awareness or valuing of other health care providers. In a classic article by Eli Ginzberg, a noted economist, the analysis of the economics of health care is revealing. He discussed economics in relation to education, reimbursement and utilization of nursing. His predictions of economic variables affecting nursing or the 80's has come to pass in many areas. These predictions included: continuing high, but receding inflationary pressures; taxpayer resistance to enlarged governmental expenditures; a shift from human resource to defense spending. These changes affected the health care delivery system by availing little or no new money to expand/improve the system. It increased pressures on providers to economize and cut back to contain costs, decreased salary and fringe benefits to nurses employed by hospitals and nursing homes, and decreased hospital beds with subsequent lay-offs of nurses. His prediction of shrinking employment markets for nurses did not occur. Ginzberg described how nursing leaders have advocated for changes in nurse practice acts to ensure an expanding pool of nurses able to use their knowledge as fully as possible. He stated **"Pressing for third party reimbursement to compensate nurses in expanded practices has fallen on deaf ears in many legislatures, although federally supported rural and inner city health centers can be reimbursed on a cost, not charge basis. This lack of reimbursement has curtailed efforts of the nursing profession to institute cost effective, alternative care innovations for the consumer, that they are capable of instituting."** He also states that physicians seek to protect their turf by making it difficult for nurses to expand their practice. This is one reason why nursing studies demonstrating cost effectiveness for a comparable quality of health care, have been largely ignored by lawmakers. He goes on to say nurse leaders want acceptance by physicians as colleagues. However, collegiality requires a change in attitudes of physicians, hospitals administrators and others in authority over nurses. Medicine especially has to recognize the revolution of the role of educated females in society today, and accept the fact that they are at the top of the totem pole not by right, but by virtue of history and tradition (Ginzberg, E. 1981).

REQUIREMENT: The social impact, including: The level of public demand for individual or group insurance coverage of the treatment or service.

For those groups or individuals who have contact with services by an ARNP the evaluations have been positive. The role of advanced registered nurse practitioners clinics as a members of the health care delivery system has been well documented. Recent studies comparing nurse practitioner visits with physician visits show that the average cost for nurse practitioners is significantly lower (39%) than the cost for a physician visit. Other findings of in this study include:

- The number of visits per patient is equivalent for nurses and doctors
- Nurses experience slightly fewer hospitalizations than did patients of physicians
- Nurse practitioners and physicians are equivalent in the number of prescriptions written
- Nurse practitioners score as high on quality care standards as physicians. This included diagnostic accuracy and completeness of care.
- Nurse practitioners prescribe more health promotion activities
- Nurse practitioners achieve equivalent outcomes or scored more favorably on some items, these include patient satisfaction with the health care provider, patient compliance with health promotion, treatment recommendations, and patients knowledge of health status and treatment recommendation (Volmut, J. 1993).

The scarcity of ARNP's as well as the relative newness of the provider group (since mid 1960's) has contributed to the lack of knowledge by the public.

REQUIREMENT: The social impact, including: The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

Not Applicable

4141 2/19/93
2-5

REQUIREMENT: The social impact, including: The impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage.

Indirect Costs-No data available.

REQUIREMENT: The financial impact, including: The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service.

While the overall financial impact of SB 187 is a reduction in health care costs, the reimbursement coverage for ARNP's may theoretically increase overall expenditures by increasing the number of providers reimbursed. This theoretical increase will be offset by the savings described in the next section. An estimate of the cost of ARNPs in 6 counties is based on the increased number of providers being reimbursed is estimated at $293,834 per year. This figure is based on the following formula:

In the six counties, there are 191 ARNP's (excluding nurse anesthetists).

	NP's	CNS's	CNM's
Douglas	3	6	1
Johnson	22	24	1
Leavenworth	2	9	0
Sedgwick	57	22	0
Shawnee	7	28	3
Wyandotte	5	0	0
Total	97	85	5

Total = 191 (Kansas Board of Nursing, February 1993)

Estimating that an ARNP charges $22/visit @ 3 visits/hour X 36 hours/week X50 weeks/year = $118,800 total billable annually (average physician charge is $28/visit).

Percent of patient charges covered in Kansas by commercial insurance is 35% :

$ 118,800 X 35% = $41,580

Billable revenue per ARNP by commercial insurance

Of the 35% of patient charges paid by commercial insurace, BCBS pays 37% of the commercial insurance market (or 13% of total charges):

$ 41,580 X 37% = $15,384

Billable to BCBS per ARNP per year

$15,384 billable to BCBS per ARNP per year X 191 ARNP's in the six counties =

$2,938,344 total per year possible billing to BCBS by all ARNP's in 6 counties

Assuming 90% of ARNP's are currently being billed under physician provider numbers:

$2,938,344 x 10% = $293,834 payable by BCBS to 10% of ARNP's that are not currently being reimbursed.

According to a 1992 survey of ARNP's in Kansas, the average annual gross income for ARNP's (excluding nurse anesthetists) is $ 40-50,000/year. A physicians salary is estimated to be 2-3 times this amount.

R rsement for coverage for ARNP's will decrease costs by:

- The physicians and ARNP's who practice collaboratively and who bill under the physician's provider number, do so now at the physician's billing rate. The ARNP generally receives a percentage of the collected fee, with the rest collected by the physician. ARNP reimbursement is generally 75-80% of the physician's rate. By billing for the service at the lower rate, costs will theoretically be decreased.
- Access to primary care, which includes prevention and education, especially when provided by an ARNP, will decrease costs due to chronic or untreated problems that require more costly services such as hospitalization .

Documentation to support the above projections follows:

Burnip, R., Erickson, R., Barr, G., Shinefield, H. & Schoen, E. (1976). Well-Child Care by Pediatric Nurse Practitioners in a Large Group Practice. American Journal of Diseases in Children, 130(I), 51-55.

Findings were: Pediatric NP's were competent in delivery of all aspects of well-child care; utilization of medical care facilities by patients or practitioners were minimally affected and a substantial reduction in the cost of well-child care occurred.

Chambers, L, Bruce-Lockhart, P., Black, D., Sampson, E. & Burke, M. (1977). A controlled Trial of the Impact of the Family Practice Nurse on Volume, Quality, and Cost of Rural Health Services. Medical Care, 15(12) 971-981.

Findings were: Costs were decreased by a shift in the location of services from the hospital to the community, with a greater emphasis on preventive services, and no change in the quality of care.

Cintron, G., Bigas, C, Linares, E., Aranda, J. & Hernandez, E. (1983). Nurse Practitioner Role in a Chronic Congestive Heart Failure Clinic: In-hospital Time, Costs, and Patient Satisfaction. Heart and Lung, 12(3), 237-240.

Findings were: A 75% decrease in total medical costs was realized due to use of the NP-staffed clinics.

Zwaag, R., Mason, W., Joyners, M. & Runyan, J. (1980). Cost of Chronic Disease Care. Journal of Chronic Disease, 33, 713-720).

Findings were: Health care was more accessible to the consumer, reduced costs without compromise in quality of care, emphasized prevention through early treatment of high blood pressure and diabetes care, uncompromised quality of care and an increase in professional contacts requiring less technological interventions, such as emergency room and hospitalization.

REQUIREMENT: The financial impact, including: The extent to which the proposed coverage might increase the use of the treatment or service.

NA

REQUIREMENT: The financial impact, including: The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service.

NA

REQUIREMENT: The financial impact, including: The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders.

The removal of the six county exclusion will not increase the premiums or administrative services of the policy holders. This conclusion is based on the following assumptions:

90% of ARNP's in these six counties are currently being reimbursed by billing their services under the physician's provider number.

The increased access to primary care will lower health care costs (see references above).

Psychiatric benefits are significantly restricted due to the prevailing sentiment that the psychiatric mandated benefits have increased insurance premiums significantly. Because of the increased number of ASO's (self-funded plans) and the minimal coverage of psychiatric benefits in policies, increased access to ARNP's who provide psychiatric services

not increase premiums significantly. Only 34 of the CNS's in the six counties are psychiatric, and they ac for only 17% of the overall ARNP population in these six counties.

Administrative services of BCBS should theoretically be reduced because of the complexity of the current billing system. By assigning ARNP's provider numbers in the urban areas, as they do in the rural areas, BCBS will have less administrative services required. Uniform policy administration should assist billing clerks and field representatives to be consistent and efficient. Consumer and provider education should be enhanced because of consistent policies.

The impact of this coverage on the total cost of health care, based on the studies available, demonstrates that access to primary care reduces health care costs. While the current health care system is cure-oriented rather than prevention-oriented, there is conclusive evidence that education, prevention, screening, primary health care and monitoring, all within the scope of practice of ARNP's, will reduce health care costs.

In an article in Medical Care (20(2), 143-153, Salkever et al describes the methods and findings of efficiency comparisons between pediatricians and pediatric nurse practitioners in a group practice HMO in the treatment of sore throats and middle ear inflammation. Nurse practitioner costs were lower, 18% below the physicians' costs in treating inflammation of the middle ear and 25% below the physicians' costs in the treatment of sore throats.

The Arizona school districts utilized NP's as primary care providers with a saving of $15,000 - 20,000 in large school districts (Sabolewski, S.D., 1981. Cost-effective school nurse practitioner services. Journal of School Health, 51(9) 585-588.)

While the direct short-term cost of reimbursing ARNP's may increase due to the number of eligible providers increasing, the long term reduction in costs to the health care system is undeniable.

FIH 2/19/93
2-8

Resources

The following available resources were used to prepare this impact report:

Report Card '92 A Publication of Partnership for Children, produced as a Joint Project of Heart of America United Way, Inc. and The Greater Kansas City Community Foundation and Affiliated Trusts.

Horak, Joseph Primary Care Survey, Wyandotte County, Kansas Department of Health and Environment, February 1992.

Kansas Association for the Medically Underserved, Service Profiles for 1992. Data from Indigent Clinics in the six counties.

Topeka-Shawnee County Health Agency application for designation as a Federally Qualified Health Center (FQHC), February 1992.

1991 Kansas Medically Underserved Areas Report, University of Kansas. December 1991

1991 Federal Medically Underserved Areas Report, Department of Health and Human Services, Division of Health.

Bryne, Canda and Jackson, Deesie 1993 Compendium of Research Articles related to Access and Cost-effective Quality Care by Nurses in Advanced Practice, Prepared by the Kansas State Nurses Asscіation, Janaury 1993.

Office of Technology Assessment, Congress of the United States Health Technology Case Study 37 Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis. December 1986

Kansas State Board of Nursing Advanced Registered Nurse Practitioners Statistics January 1993.

The following individuals and organizations were contacted for other "available" data for this report.

Kansas Insurance Commissioners Office, ARNP cost data.

Blue Cross and Blue Shield, Kansas, ARNP cost data.

Blue Cross and Blue Shield, Kansas City, Reimbursement policies.

Kansas Department of Health and Environment, Volume of consumers in these six counties not having access to primary care, all populations.

ASK A NURSE, St. Francis Hospital and Medical Center, Topeka: physician services availability.

7141 2/19/93
2-9

February 10, 1993

Senator Dick Bond and Senate Insurance Committee Members:

I am Susan Alexander. I graduated from the University of Kansas with a Bachelor of Science degree in Nursing and I am presently a student in the Family Nurse Practitioner program at Fort Hays State University. I have been employed in both the rural and the urban setting during my practice years. As the director and care provider of a private, non-profit home health service, and former director of the volunteer EMS in the medically underserved county of Chase, I support Senate Bill #187 which would provide third party reimbursement to nurse practitioners in the six county urban areas of Kansas.

The reimbursement policy would make more readily available, provision of mid-level primary care which, with fewer family practice physicians, has become increasingly difficult to obtain. As a provider of home health care, I see a need for additional primary care in both the rural and urban areas. The impact of availability of mid-level primary care and treatment rather than provision of acute care after the development of serious illness would advantageously affect the burden on the government by decreasing the amount expended for acute care. Concurrently, it would impact the population of Kansas by improving the quality of life and health of Kansans. Thank you.

Sincerely yours,

Susan D. Alexander, RN, BSN

Susan D. Alexander, RN, BSN

Senate 7-1-1
2/19/93
Attachment #3

I am Dr. Ralph Weber, Vice President of Medical Affairs, at Blue Cross and Blue Shield of Kansas (BCBS). I would like to share with you our concerns relating to the proposed changes to KSA 40-2250 and to respond to previous testimony that has been presented.

First, it appears that the intent of the Legislature in pursing HB 2888 was to provide Kansas citizens in medically undeserved counties expanded access to health care providers by allowing Advanced Registered Nurse Practitioner (ARNPs) to engage in independent practice in those counties. BCBS is not aware that there is an acute shortage of physicians in the metropolitan counties of Douglas, Johnson, Shawnee, Sedgwick or Wyandotte counties for patients able to pay for services. We admit that certain individuals in these counties may have access problems as a result of financial limitations, ie, inability to pay, rather than an adequate availability of physicians. We are concerned that if ARNPs are allowed independent practice in the more socially attractive metropolitan communities, there is no assurance that these individuals will not migrate, like the physicians before them, out of the rural areas thereby compounding the access problems in those areas. Likewise, requiring insurance companies to pay ARNPs directly in metropolitan counties will not solve the access problems for citizens in those counties who do not have insurance or can't afford health care.

Secondly, passage of this legislation will only serve to inflate the premiums for those who do purchase insurance. Put simply, the costs of insurance is directly proportional to the cost of services times the number of services performed. BCBS opposes the creation of yet another group of independently practicing health care professionals in Kansas metropolitan communities as it will duplicate services already being

Senate 7/41
2/19/93
Attachment #4

performed in these communities and will only result in more services which will be reflected to our insureds in higher premiums.

You have previously heard testimony indicating that ARNPs both charge and are reimbursed less than physicians and thus are more cost effective. Our reimbursement system does not distinguish reimbursement on the basis of the type of provider and allows all eligible providers their charges up to a maximum allowable payment established for each service. Our claims data reveal that ARNPs, like all other providers, consider their services to be just as valuable as a physician's and like a physician charge what the economic and competitive environment of their practice location allows. In other words, in a given county, ARNPs in independent practice charge essentially the same amount as physicians in that location and thus do not provide any cost savings to the payor.

Finally, passage of this legislation will not resolve the ARNPs concerns regarding BCBS' reimbursement policies. Since passage of HB 2888, our staff has had several meetings and correspondence with the Kansas State Nurses Association regarding these issues. Prior to and currently since passage of HB 2888 in the contested metropolitan counties, we have always administratively reimbursed the health care provider (ie, physician, health department, facility) for the contractually covered medical services that their ARNP employees provide. The Kansas Nurses Association has expressed concern that we will change that policy and begin to not pay for services of ARNPs where they are not mandated. Today I am assuring this committee we have no intentions of changing that policy. However, we do not and will not reimburse for contractually non-covered or excluded services such as nurses assisting at surgery. We also will not pay for services which

an ERISA self insured group have excluded such as psychiatric outpatient services.

In conclusion, I would like to emphasize that BCBS of Kansas recognizes that ARNPs provide capable, cost efficient services. We endorse the concept of allowing ARNPs to practice independently in those rural communities without direct physician services. We do not, however, condone the expansion of their independent practice into metropolitan areas as this would be inflationary for our insured's insurance premium and will not resolve the access problem for those without insurance. It appears that this legislation has been proposed to establish independent practice in metropolitan counties for the personal gains of a very limited number of ARNPs. It offers no solutions for resolving the significant issues of containing the costs of health care. At a time of inability of limited health care financial resources to meet the increasing demands of the health care system, BCBS of Kansas is concerned at the plethora of legislation currently being introduced by selective provider groups that appear to be motivated towards securing a greater portion of that limited dollar for their benefit rather than proposing solutions for containing the excessive cost of health care.

7/14 2/19/93

4-3