Approved: 3-4-93
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 25, 1993 in Room 526-S of the Capitol.

All members were present except: Senator Jones, Excused

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Jerry Slaughter, Kansas Medical Society
Donald Wilson, Kansas Hospital Association
Jim Schwartz, Kansas Employer Coalition on Health
Robert Harder, Secretary, Kansas Department of Health and Environment
George Goebel, AARP
Donna Whiteman, Secretary, Kansas Department of Social and Rehabilitation Services

Others attending: See attached list

Hearing on **SB 118** - Collection of health care data by the department of health services administration at KU.

The Chair briefed the Committee on the essential elements of **Substitute for SB 118** which came about as a result of various groups trying to work out their differences. In answer to a member's question in reference to "board" in the bill, the Chair stated the board will not be reimbursed and is totally voluntary, and language in Section 5, line 23, "shall file annually health care data with the department as prescribed by the board" will be clarified to read through rules and regulations as adopted by the secretary. It was noted that by next year information would be known if the institute as referenced in the bill would be established in association with the department had been funded, how the institute will be able to participate in this process and what kind of expenses would be encountered in terms of data collection from the state. The institute can fund some data collection through the moneys they will receive, but not until that grant has been approved, and the bill as written, does not require a fiscal note this year.

Staff briefed the Committee on ERISA -- ERISA participants are exempt from state insurance statutes and regulations and do not have to comply with any state regulatory laws -- and noted that in Section 5, line 22 regarding self-funded employee health plans having to file health data, that language may not be a problem to the extent that not all self-funded employee health plans are ERISA benefit plans, and those that are would probably be exempt under ERISA from providing any information -- unfortunately those are the largest groups and no waivers could be obtained.

Jerry Slaughter, appeared in support of **Sub for SB 118** as well as the original bill and noted that the blend of the two concepts with the Department of Health and Environment as the depository information for data collection is a positive step toward putting Kansas ahead of other states in dealing with health reform.

Donald Wilson, KHA, also appeared in support of **Sub for SB 118**.

Jim Schwartz, representing Kansas Employer Coalition on Health, Inc., stated his original testimony asked for an amended bill and is now supportive of **Sub for SB 118**. (Attachment 1) Mr. Schwartz agreed to supply a list of KECH members who would comply in providing data.

Robert Harder, Secretary of Health and Environment, expressed his support for **Sub for SB 118**.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE, Room 526-S Statehouse, at 10:00 a.m. on February 25, 1993.

Donna Whiteman, Secretary of SRS, stated her original testimony was in opposition to **SB 118** and felt **HB 2371** would provide the necessary information base for improved decision making and policy development that would promote greater access, enhance quality of services and constrain unwarranted costs. Secretary Whiteman noted that **Sub for SB 118** is a good step in the right direction and would recommend language be drafted in the bill to include medicaid, and her staff will provide input in order to maximize those federal dollars. A member requested that SRS staff analyze what additional requirements might be imposed as a result of including medicaid in the bill. (Attachment #2)

George Goebel, AARP, expressed his support for **Sub for SB 118** stating his organization has been working a long time for health reform and that this bill is a positive step toward that goal.

Final action on **SB 176** - Smoking in medical facilities prohibited.

Senator Hardenburger made a motion to include an amendment on page 1, line 22, after the word "except", insert the following: "for a patient by a physician's prescription, based on medical criteria that are defined by the medical staff, or". Committee discussion related to a physician's order for a patient to smoke in a hospital and whether the medical staff sets policy for a hospital or make recommendations to the hospital board, and whether that patient would be confined to his/her private room. The motion was seconded by Senator Langworthy. Senator Papay made a substitute motion that the amendment include "in a private room". No second on the substitute motion. Back to the original motion. The motion failed. Senator Walker made a motion to recommend **SB 176** favorably for passage, seconded by Senator Lee. The motion carried.

Final action on **SB 177** - Use of tobacco products prohibited on school grounds.

Senator Walker made a motion to recommend **SB 177** favorably for passage, seconded by Senator Papay. The motion carried.

Final action on **SB 248** - Examination fees for marriage and family therapists and psychologists.

Senator Hardenburger made a motion to recommend **SB 248** favorably for passage, seconded by Senator Langworthy. The motion carried.

The Chair reviewed the agenda for the following day.

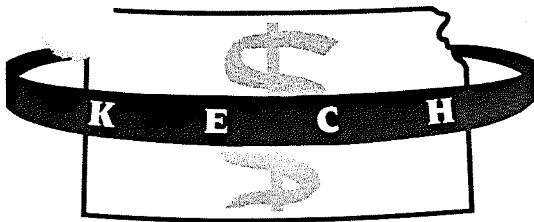
The meeting was adjourned at 11:00 A.M.

The next meeting is scheduled for February 26, 1993.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 2-25-93

NAME	ADDRESS	COMPANY/ORGANIZATION
John Peterson	Topeka	Ks Hospital Assn
Millie Walter	Topeka	EDS
Ronald Fraass	Topeka	KDHE/BAR
R Epps	Topeka	SRS
Mack Smith	"	State Board of Mortuary Arts
Lyndon Drew	Topeka	KDOA
David Hanzlick	Topeka	KDA
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS
George Goebel	Topeka	AARP SLC-CCTF
Katie Ryan	"	" "
Mike Speaght	Topeka	Ks. Foundation for Medical Care
Jim Schwartz	Topeka	KECH
[illegible]	Topeka	KMS
Chip Wheelen	Topeka	Ks Medical Soc.
William SNEED	TOPEKA	HIAA
Harold Spiker	Topeka	KDHE
[illegible]	Topeka	Hein, Ebert & Rosen



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

Testimony to Senate Public Health and Welfare Committee

on SB 118

(Establishes method of collecting health care data by KU)

by James P. Schwartz Jr.
Consulting Director
February 25, 1993

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is over 100 employers across Kansas who share concerns about the cost of health care for our 350,000 Kansas employees and dependents.

I come to you today representing not only the coalition, but also a task force that has been meeting since last summer to advance the cause of health care information in Kansas. That task force includes this coalition, AARP and the Kansas Department of Health and Environment. It also reflects interests of many other parties who participated in the task force.

The task force believes that the aims of SB 118 are sound. We also believe that the public interest would best be served by expanding the bill to establish a reliable database of health care statistics, accountable to the public. We see the University of Kansas initiative as fully compatible and complementary with formation of a database of health-care use, cost and demographics. By having such statistics stored in a uniform fashion in one pool, users like KU would have ready access to reliable, up-to-date information on which to base their analyses.

As we enter a new era of health system reform based on "managed competition," the need for information will be more important than ever. Of course, data alone will not overhaul our ailing system, but I hope all

Senate PH&W
Attachment #1
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of us can agree that it is a necessary ingredient for progress. States that can form policy based on sound data will doubtless be able to exercise more autonomy within a national framework.

Managed competition heightens the need for information in both the public and private sectors. The public sector needs to monitor access and demographics of care. Both public and private sectors need to account for variations in utilization and cost of services. For instance, the current effort to establish a fee schedule for Workers Compensation has been severely hampered by a lack of information on prevailing charges. The function of a database would be to pull together all the scattered clumps of health data into a single, efficient, credible body of knowledge.

We contend that health care is a social good and that sources of health data have a responsibility to share basic information with the public. We ask that SB 118 be amended to reflect such an imperative.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

Senate Committee on Public Health and Welfare
Testimony on Senate Bill 118

February 25, 1993

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SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

****

Madam Chairman, Members of the Committee, thank you for this opportunity to address you regarding Senate Bill 118. This bill authorizes the Department of Health Services Administration of the University of Kansas to request various forms of health care data for the purposes of conducting research, policy analysis and the preparation of reports describing the performance of the health care delivery system from the perspectives of public, private and quasi-public entities. SRS opposes Senate Bill 118.

The collection and dissemination of data concerning the uses and costs of health care services has been mandated in at least thirty states. These data bases represent a valuable resource for state policy makers to address complex health issues, contain rising costs, and manage parts of the health care system. As health care costs continue to rise and the number of people who lack access to appropriate care, increase the need for accurate and timely health care data will grow in importance. If states, like Kansas, are to achieve significant control of their health care expenditures, they must understand health care utilization and cost. States must have the capacity to conduct quality health policy analysis, which is dependent on good health care data.

A number of organizational structures are used to support state data programs. One form is an independent commission that is responsible for the collection and release of data. Florida, Colorado, Illinois, and North Carolina are among the states that have data commissions. These commissions include representatives of health care providers, businesses, insurers, and consumer groups.

Another form of organization is to house the data program in the state's health planning or regulatory agency. California, Massachusetts, Minnesota, Maine, North Dakota, and Ohio include the data collection analysis and dissemination program in their state health agency. This structure allows for easy integration of the data into the overall development of health policy. Major executive branch health policy makers and state legislators have ready access to the data.

Still, an other model used by some states separate data collection from data use and dissemination. Both Wisconsin and Vermont have hospital discharge data processed by their centers for health statistics, but their data analysis and dissemination are done by a commission or health office. South Carolina has

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located their data collection function in an agency that handles only data and that is not part of the health department. Some states have reported that the separation of the data and policy functions results in more objective research.

The organizational location and structure of a health care data function should facilitate the integration of such data into the development of state health policy. Within the executive branch of Kansas state government the Department of Health and Environment is the logical and appropriate location for this important function. Conversely, the data function should be not placed within the University of Kansas because of potential conflicts of interest involving the University's considerable health care functions at the Kansas City and Wichita branches of the medical center. The University's unique governance structure could also impede accessibility of the data to state policy makers.

The "public/private" funding proposal that has been discussed in connection with the location of this function at KU is wrong because future funding would not be assured. The private interests could withdraw financial support at any time. The short-term benefits of privately funding this important new function will be minimized if the data function is not held to the highest standards of public accountability.

While opposing Senate Bill 118 we believe that the alternative health care data program envisioned in House Bill 2371 will provide the informational base for improved decision making and policy development that promotes greater access, enhances quality of services and constrains unwarranted costs. The benefits of a well designed and strategically placed data function will certainly outweigh any associated costs to the state. Senate Bill 118 it unwisely places this important function away from the center of state health care policy making. I encourage your favorable consideration of House Bill 2371 which appropriately places the data function in the Department of Health and Environment.

Session of 1993

HOUSE BILL No. 2371

By Representatives Helgerson, Alldritt, Charlton, Gilbert, Hochhauser, Larkin, McKechnie, McKinney, Pettey, Reardon, Sader, Sawyer, Sebelius, Standifer, Swall, Wagnon, Watson, Weiland, Weinhold, Welshimer and Wootton

2-5

11 AN ACT authorizing the secretary of health and environment to
12 collect health care data; creating the health care data collection
13 advisory board.
14
15 *Be it enacted by the Legislature of the State of Kansas:*
16 Section 1. (a) The secretary of health and environment is hereby
17 authorized to collect health care data pursuant to the provisions of
18 this act.
19 (b) The secretary shall compile the data to:
20 (1) Produce health care information for use by health planners
21 and policymakers in evaluating medical needs, resources and options
22 for public policy;
23 (2) furnish health care information for use by hospitals, physicians
24 and other health care providers in the interest of quality improve-
25 ment, needs assessment and efficient delivery of care;
26 (3) provide health care information for use by third-party payers
27 in order to create a more accountable and comparable market for
28 medical services;
29 (4) assure availability of an information system that is ongoing,
30 reliable and publicly accountable; and
31 (5) target consumer and patient advocacy groups as users of the
32 collected data.
33 (c) The secretary shall have the following functions, duties and
34 powers to:
35 (1) Develop a statewide health care database for the collection,
36 analysis and dissemination of information applicable to the uses set
37 forth in subsection (b);
38 (2) include in that database information on health care quantity,
39 quality and price; information on health care providers; and patient
40 and payer demographics;
41 (3) publish reports that make meaningful distinctions among
42 health care providers, assess such providers' performance and provide
43 a basis for negotiations between providers and purchasers;

(4) contract with a firm, corporation or other entity to assist in the compilation, correlation and development of the data collected;

(5) require any health care provider, as defined in K.S.A. 65-4921, and amendments thereto, or medical care facility, as defined in K.S.A. 65-4921, and amendments thereto, to provide health care data as established by rules and regulations. Such data shall not identify patients but shall identify providers and facilities;

(6) require all third-party payers, including but not limited to, licensed insurers, medical and hospital service corporations, health maintenance organizations and self-funded employer health plans, to provide health care data as established by rules and regulations. Such data shall not identify patients but shall identify health care providers and medical care facilities; and

(7) adopt rules and regulations to implement and enforce this act.

Sec. 2. (a) There is hereby created the health care data collection advisory board.

(b) The board shall consist of 9 members. Seven members shall be appointed by the governor as follows: One member who is a provider of health care insurance; one member who is licensed pursuant to the Kansas healing arts act; one member who is a representative of a health facility, as defined in K.S.A. 65-4801, and amendments thereto; one member who is a representative of the university of Kansas school of medicine; and three consumer members. One member shall be the secretary of social and rehabilitation services or the secretary's designee. One member shall be the commissioner of insurance or the commissioner's designee. The secretary of health and environment shall be an ex officio member who shall be the chairperson of the board. Board members shall not be compensated for their services. The board members shall serve for three-year terms, or until their successors are appointed and qualified.

(c) The secretary of health and environment shall call the first meeting. The board shall meet at least annually and at such other times as provided by the secretary.

(d) The advisory board shall:

(1) Recommend to the secretary policy regarding the development of, research on and uses of health care data collection;

(2) provide direction to the secretary of health and environment for pertinent studies; and

(3) develop programs to increase information available from the data base to improve health care purchasing and delivery for Kansans.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

MAJOR ELIGIBILITY CATEGORIES OF THE KANSAS MEDICAL ASSISTANCE PROGRAM

Kansas Department of Social and Rehabilitation Services

Division of Management Services Budget Office

Based on FY 92 Appropriation as of 3/12/92

AID TO FAMILIES W/DEPENDENT CHILDREN — 1

Anyone receiving AFDC is automatically given a Medical card. Families average well under 12 months on AFDC, particularly two parent ones. The maximum grant in most cases is only $396 per month. This amount is reduced nearly dollar for dollar for earnings, unemployment comp, or other income. Nearly half of all medical expenses involve childbirth/newborn care.

FY 92 Average monthly caseload:	83,000
Number of different persons served:	142,000
FY 92 Average monthly medical cost:	$100
FY 92 Total cost per GBR:	$100,000,000

Top Five Services	
Inpatient Hospital	$50,000,000
Physician Services	23,000,000
Prescription Drugs	8,000,000
Outpatient Hospital	5,600,000
Dental Services	3,000,000

MEDICALLY NEEDY–AFDC FAMILY — 1a

If a family meets all the criteria for being on AFDC but their income is too great, they may still receive a Medical card. They will need to devote all income above $470 (family of three) toward medical expenses. If they has expenses beyond this, Medicaid will pay them–if they are a covered service. If their monthly income is below $470 their is no requirement that they pay toward a covered service. The $470 figure is known as the Protected Income Level (PIL). The income in excess of this that they must first devote to medical expenses is known as the "spend–down" amount.

FY 92 Average monthly caseload:	3,900
Number of different persons served:	17,000
FY 92 Average monthly service cost:	$128
FY 92 Total cost per GBR:	$6,000,000

Top Five Services	
Inpatient Hospital	$3,000,000
Physician Services	1,000,000
Outpatient Hospital	500,000
Dental Services	400,000
Prescription Drugs	300,000

AFDC EXTENDED MEDICAL — 1b

The majority of AFDC families who, by obtaining employment are no longer need AFDC assistance, are eligible for a 12 months of transitional Medicaid coverage. This gives the family time to establish themselves financially. This was a mandated coverage group on the Family Support Act which created the JOBS program. A family does not have to participate in that program in order to receive this transitional coverage.

FY 92 Average monthly caseload:	10,000
Number of different persons served:	25,000
FY 92 Average monthly service cost:	$58
FY 92 Total cost per GBR:	$7,000,000

Top Five Services	
Inpatient Hospital	$3,000,000
Physician	1,700,000
Prescription Drugs	700,000
Outpatient Hospital	600,000
Dental Services	400,000

SUPPLEMENTAL SECURITY INCOME — 2

Anyone receiving SSI is automatically eligible to receive a Medical card as well. They must apply for the card at an SRS Office for us to be aware aware of their SSI status. A large percent are on Medicare. These individuals seek M'Caid for Nursing Home and Rx expenses.

	Aged	Disabled
FY 92 Average monthly caseload:	7,100	17,300
Number of different persons served:	8,100	21,000
FY 92 Average monthly service cost:	$354	$465
FY 92 Total cost per GBR:	$30,200,000	$96,500,000

Top Five Combined Services		
Adult Care Home/HCBS	$17,000,000	$34,000,000
Inpatient Hospital	3,000,000	28,000,000
Prescription Drugs	6,000,000	11,000,000
Physician Services	500,000	7,500,000
CMHC/Psychologists	50,000	6,400,000

MEDICALLY NEEDY–AGED/DISABLED (SSI) — 2a

If a person meets all the criteria for being on SSI but his income is too great, he may still receive a Medical card. He will need to devote all income above $442 ($30 for ACH client) toward medical expenses. If he has expenses beyond this, Medicaid will pay them–if they are for a covered service.
The vast majority of these people were well covered by Medicare and perhaps a MediGap policy. That is until they entered an ACH.

	Aged	Disabled
FY 92 Average monthly caseload:	14,300	3,900
Number of different persons served:	21,500	8,000
FY 92 Average monthly service cost:	$995	$1,165
FY 92 Total cost per GBR:	$170,700,000	$54,500,000

Top Five Combined Services		
Adult Care Home/HCBS	$145,000,000	$37,000,000
Prescription Drugs	15,000,000	4,000,000
Inpatient Hospital	3,000,000	6,000,000
Medicare Premiums	5,900,000	1,500,000
CMHC/Psychologists	100,000	2,200,000

QUALIFIED MEDICARE BENEFICIARY (QMB) — 2b

When Congress created the ill–fated Medicare Catastrophic Care Act it's financing was to come from greatly increased Medicare premiums. To protect the lower income Medicare beneficiary Congress ordered the states Medicaid program to pay these higher premiums for poverty–level persons. While the MCCA was repealed, this provision was not. We now pay the Medicare premiums, deductibles, and co–payments for anyone below 110% of the federal poverty level. This is a monthly income of $624.

FY 92 Average monthly caseload:	2,400
Number of different persons served:	5,000
FY 92 Average monthly service cost:	$52
FY 92 Total cost per GBR:	$1,500,000

Breakdown of aid:	
Medicare Premiums	$1,100,000
Inpatient Copay/Deductible (Part A)	130,000
Outpatient Copay/Deductibles (Part B)	270,000

FOSTER CHILDREN/ADOPTEES — 3

These are children in the custody of the SRS for a variety of reasons. This also includes approximately 500 children who have been adopted and because of special needs are still being supported medically by the Medicaid program. NOTE: Over 3/4ths of all expenses involve psychiatric care.

FY 92 Average monthly caseload:	5,700
Number of different persons served:	9,600
FY 92 Average monthly service cost:	$205
FY 92 Total cost per GBR:	$14,000,000

Top Five Combined Services	
Inpatient Hospital	$5,500,000
CMHC/Psychologists	2,400,000
Rehabilitation (Level 6 Homes)	2,150,000
Physicians Services	1,600,000
Prescribed Drugs	650,000

LOW INCOME PREGNANT WOMEN AND CHILDREN — 4

Any of the following persons are eligible, regardless of the families marital situation, upon applying. This population is a product of several progressively more liberal federal OBRA's intended to address this nations poor infant mortality/low birth weight performance.

	If Family Income:	Monthly For Fm
Pregnant Women	< 150% FPL	$1,448
Infants under 1 yr old	< 150% FPL	$1,448
Children ages 1 thru 5	< 133% FPL	$1,285
Children ages 6 and up if born after 9/30/	< 100% FPL	$964

	Women	Children
FY 92 Average monthly caseload:	3,400	13,000
Number of different persons served:	11,000	31,000
FY 92 Average monthly service cost:	$686	$115
FY 92 Total cost per GBR:	$28,000,000	$18,000,000

Top Five Services	
Inpatient Hospital	$29,500,000
Physician Services	11,000,000
Outpatient Hospital	1,400,000
Prescription Drugs	1,200,000
Lab and X–Ray	500,000

MEDICAID AND MEDIKAN FOR GEN ASST CLIENTS — 5

There are two populations on the GA Cash Assistance program. First are families who, while poor, cannot qualify for AFDC due usually to the presence of two parents in the home. All children in these families, as well as all pregnant women, are MEDICAID clients.
The larger group are individuals who are disabled for 30 days or more who do not yet have a decision regarding permanent federal disability status. These are MEDIKAN clients.

	Disabled	Family
FY 92 Average monthly caseload:	4,400	2,400
Number of different persons served:	10,000	6,600
FY 92 Average monthly service cost:	$436	$153
FY 92 Total cost per GBR:	$23,000,000	$4,400,000

Top Five Services		
Inpatient Hospital	$14,000,000	[illegible]
Physician	3,000,000	[illegible]
CMHC/Psychologists	2,000,000	[illegible]
Prescribed Drugs	1,500,000	300,000
Outpatient Hospital	700,000	500,000