Approved: April 7-94
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on March 23, 1994 in Room 423-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Bill Roy, Kansas Commission on Future of Health Care, Inc.
Barbara J. Gibson, Kansas Commission on Future of Health Care, Inc. Commission member
Myron Leinwetter, D.O., Kansas Commission on Future of Health Care, Inc. Commission member
Hal Hudson, State Director, National Federation of Independent Business
Paul Fleener, Director, Kansas Farm Bureau
Jerry Slaughter, Executive Director, Kansas Medical Society
Walter H. Crockett, Kansas AARP
Robert Durst, M.D. Dermatology, Topeka, Kansas
James Hamilton, M.D., Surgeon, Topeka, Kansas
Joyce Sugrue, for Secretary Whiteman, Department of SRS
Terry Leatherman, Executive Director, Kansas Industrial Council, Kansas Chamber of Commerce/Industry
Sharon Huffman, Kansas Commission on Disability Concerns
Melville W. Gray, interested citizen
Jim DeHoff, Executive Secretary, Kansas AFL-CIO
Larry W. Magill, Jr. Executive V.Pres, Kansas Association of Insurance Agents
Michael R. Todd, Health Care Reform Coalition
Mike Oxford, Kansas Association of Centers for Independent Living
Edward Rowe, member of lobby Corp, League of Women Voters of Kansas
Dr. Robert C. Harder, Secretary, Department of SRS (written only)

Others attending: See attached list

Chairperson Flower called the meeting to order at 1:00 p.m., welcoming all those present. She requested that all conferees be courteous to one another in limiting their time to 3-5 minutes in order that all may be able to present their comments. Chair has decided to alternate the proponents and opponents so that both opinions will have been fairly heard, should time not permit all conferees to present their comments.

Dr. Bill Roy, Sr., Commission on Future of Health Care, Inc. (see Attachment No. 1), gave background information regarding the Kansas Commission on the Future of Health Care, noting the Commission worked for 28 months, spent over 150 hours, and attended 58 community meetings. The Commission believes it is of vital importance that all Kansans have health care coverage which is affordable. This belief has been echoed over and over as they engaged in dialogue with Kansas citizens across the state. Seven of eleven Commission members were health professionals with many years of clinical experience. All Commission members worked hard, put aside political and philosophical differences, engaged in open, honest, and healthy debate. He stated, much preliminary work must be accomplished if the state is to be in a favorable position to accommodate and influence federal reform efforts. Being a proactive state means we will be prepared and ready for federal action, rather than being a passive recipient of federal directives. Dr. Roy introduced Ms. Gibson. (Proponent)

Barbara J. Gibson, Board member of Kansas Commission on Future Health Care offered rationale for the Commission's recommendations to establish a Kansas Health Care Commission as set forth in **HB 2699,** now entitled a Health Council in **HB 3075.** Consideration of financing and delivery options; cooperative efforts with relevant agencies and groups to develop an integrated health plan; monitor trends in health care spending; development of plans for cost containment; coordinate integration of other health care providers and clinics into the state health care system. She noted the Commission has attempted to create an entity that would devote it's time solely to the success of this program. They would examine options and develop recommendations for the consideration of the Legislature. Other states have such programs, and have been successful. This success coming through bipartisan activity involving both the legislative and executive branches of government. She detailed composition Council appointments. She then introduced Dr. Myron Leinwetter. (Proponent)

Dr. Myron Leinwetter, practicing physician, representing the Kansas Association of Osteopathic Medicine, on the Commission, offered his thoughts on why the state needs to address health care reform now. He noted this is a problem affecting thousands of Kansans, i.e., individuals not dissimilar to those present today. A reporter with a young son with disabilities requiring frequent physical therapy; a young professional whose wife had a heart defect and their health insurance is costing 40% of their income. He named countless other examples. He noted every day, he encounters people who cannot wait a decade for policy makers to enact comprehensive reform legislation. It is imperative that Kansas begins to seriously address health care reform, putting the machinery in place during this legislative session. He noted the same health care reform issues that were requested in **HB 2699** are also included in **HB 3075** for the most part.He expressed thanks to the 403 Commission for the opportunity to convey his views on health reform issues. (Proponent)

Hal Hudson, State Director, National Federation of Independent Business (NFIB) offered hand-out (Attachment No.2). He spoke in opposition to **SB 3075**, noting he represents 8,000 members employing, 100,000 Kansans who expressed on ballots, surveys, questionnaires distributed by the NFIB, i.e., 87.2% are opposed to a universal health care access plan run by the State of Kansas. He explained, and noted it is too soon to know what is coming out of Washington D.C., no idea of costs. This legislation relates to employers of business who employ 100 or less, and there are 110,000 of these small businesses in Kansas. He urged for defeat of **HB 3075.** Noted, that after what the House did to **SB 612** today, he isn't sure that **HB 3075** is even needed at all. The items that can and cannot be supported by the NFIB members were listed in his attachment. (Opponent)

Paul Fleener, Director, Public Affairs, Kansas Farm Bureau, drew attention to a strong policy position by their members on rural health care contained in his hand-out, (Attachment No.3). He stated opposition to **HB 3075,** noting it is untimely; does not contain sufficient Legislative involvement that is necessary; it pre-supposes the steps out in front of the debate on health care reform in the Congress of the United States. He noted the state needs to be coordinated with health efforts coming from the federal government, with providers and consumer groups to develop an integrated health plan for all Kansans. He indicated **HB 3075** creates several layers of bureaucracy, with duties described that could be, should be undertaken by House and Senate Committee on Public Health and Welfare. These levels of bureauracy are within a framework that is top-down, i.e., all groups created under **HB 3075** would be under the sole control of the Governor and the look of the council, the look of the advisory committees, and staffing pattern for all levels would or could change following each gubernatorial election. This legislation seeks to bring a solution to problems that are somewhat closer to being resolved through the federal examination of health care reform. (Opponent)

Jerry Slaughter, Executive Director, Kansas Medical Society (KMS) (Attachment No.4), reviewed what the principles KMS believes are fundamental in any health care reform plan, i.e., support the notion of universal coverage with shared financial responsibility among individuals, employers and government; support for programs to train and maintain an adequate supply of primary care physicians in order to improve access to care in underserved areas; freedom of patients to select the physician and health plan of their choice; competition in the marketplace to slow spending for health care; elimination of needless bureaucracy and administrative costs; keep medical decision-making with physicians and patients and protecting the spreading dominance of corporate and government intrusion; remove antitrust barriers so physicians can work to develop competitive-cost-effective health plans. He stated, they are not sure what the status of **HB 3075** is in relation to **SB 816.** He pointed out the difference between the composition of the Council in **HB 3075,** and the Oversight Committee in **SB 816**, noting the difference is significant since the decisions to be made regarding health reform will certainly involve tax policies, and these decisions can be made only by the legislature. If the legislature is to be responsible for establishing policy, it would seem more sensible to involve legislators in the process which designs the system of health reform. (Opponent)

Mr. Walter H. Crockett, representing AARP, (Attachment No.5), approached the comparison of **SB 816** and **HB 3075** in his remarks. An advantage he stated, is that **SB 816** involves legislators in monitoring federal actions, in studying the state's health care needs, and in drafting the bills that eventually will emerge. However, he doubts a ten-member legislative Committee can effectively coordinate the work that would be required along with all of their other responsibilities. **HB 3075** does provide at least the possibility, not of bureaucracy run wild, but of effective administration. He urged the merging of legislative members into **SB 816,** as proposed in **HB 3075,** perhaps with fewer than 10 members and an administrative structure such as proposed also in **HB 3075.** He then urged that this House Committee on Public Health and Welfare to merge **SB 816** and **HB 3075** by combining (1) legislative representation on a council or commission with an effective administrative structure and (2) establishing a reasonable timetable for the development of health care reform in Kansas. (Proponent)

Robert D. Durst, M.D. Dermatologist from Topeka (Attachment No. 6, A-B-C) called attention to the hand-outs. He stated the great debate is i.e., one side feels we need greater governmental intervention with more controls, rules, regulations, more surveillance powers in order to control costs. The second approach attempts to empower people, the patients, who receive medical services with incentives to act more responsibly in controlling health care costs by lifestyle modification, i.e., making the best choices if given incentives and responsibility in a free market system. A current problem is that 75% of health care expenses are directly paid by someone other than the patient. 95% of hospital costs, 82% of physician costs also fall within this category. Government accounts for 43% of all health care expenditures, while private insurance covers 43%. Much of these escalating, uncontrollable expenses have been created by governmental intervention. He related a story of a new prescription out for cirrhosis that costs $100 for only a few days of treatment. He and the pharmacists had a discussion regarding the reality of how few people could afford such a costly prescription. The reality is the health plans pay for expensive medications such as this, so it would appear there is a need to re-focus the thinking of bringing down costs, rather than expect agencies to pick up these costs. The power should be returned to the people to, i.e., prudently select their own health insurance; prudently consume health care resources; strive for a healthy lifestyle, so individuals can continue to be productive and consume a minimum of health care services. (Opponent)

Will Hendricks, interested citizen, (Attachment No.7). He has no ax to grind, no connection to the health care industry, but expressed concerns for health care for his children. He does support **SB 3075**, since the 403 Commission termination. He stated, we can continue the present chaos, support the Clinton plan with all its flaws, or we can enact **SB 3075** and begin developing a Kansas Plan for Kansans. This is not a partisan issue. Kansans do care about health care reform but are being buried in mis-information, i.e., many health plans will not save money; many will not improve quality of care; in many instances, you will not have the ability to choose your own doctor; many plans do not solve the worry about major illness bankruptcy. He detailed mis-information regarding raising of taxes to pay for new health care plans; insurance companies looking over the shoulder of physicians; mis-information regarding HMOs; mis-information regarding increasing costs for high tech medicine; mis-information regarding providing universal access/comprehensive care on a timely basis. He stated, there is a need for Kansans to stand up and fight for the health care future of Kansas. **HB 3075** will form the Kansas Health Council to provide for these needs. He does support the independence of the physician, and also feels they should be protected from encroachments by outside forces. He is in agreement also that small businesses should not be imposed upon for health care plans. (Proponent)

James Hamilton, M.D., General Surgeon, Topeka stated, essentially what we are all talking about today, is rationing of health care for a fixed dollar cost. This is a very complex and difficult issue i.e., how fairly can the health care be distributed. He stated, as a physician, he doesn't want to be placed in a position of having to be a rationer of care on the one hand, and a major provider of care on the other hand, or, to be placed in a position where he is an employee of an insurance company in terms of managed care. He explained the difficulty, if you might have to deny a patient care. Traditionally physicians have always worked to provide the most care for patients that they can. He favors any system that will allow physicians to continue to work together with their patients, not on where we need to focus more on saving money for either a government agency, or a private insurance company. He stated he wouldn't like being a rationer of care. These are weighty issues, he stated, and when we assume any national health plan of any scope, you as legislators will assume that responsibility. That is a very dangerous thing to do, and he asks that it is done very carefully, because what physicians do for their patients depends on that. Whatever kind of rationing is to be done must be very well thought out; very well reasoned, so that what physicians do for their patients is not done primarily to save money, but is to offer needed care. This is what health care is really about, i.e., not to save dollars, but to have every dime spent making someone's life better. That is the goal of any responsible physician. (Opponent) (Chair requested that Dr. Hamilton provide written testimony at a later time.)

Joyce Sugrue Department of SRS, spoke on behalf of Secretary Whiteman. (Attachment No. 8). She stated the Department is in favor of the creation of a council where efforts for health care reform are centralized and compliance with federal requirements are assured. They recommend the council include representation from the Department as SRS as the single state agency for Medicaid policy and regulations. Kansas Medicaid serves 195,000 Kansans monthly. She drew attention to concerns, i.e., to make sure that federal funding will not be lost; adequate and appropriate time-lines would need to be established for the appointment of the Kansas Council, purchasing cooperative and advisory committees; that consumers become more involved on committees so their needs can be addressed by health care providers, and those needs be met. She drew attention to the hand-out that explains how the Department is moving forward with managed care. (Proponent)

Terry Leatherman, Executive Director, Kansas Industrial Council, Kansas Chamber of Commerce and Industry, stated their organization reluctantly opposes **HB 3075,** and regret they cannot support it. They feel the heart of **HB 3075** is the creation of the Kansas Health Care Purchasing Cooperative. The Cooperative has a laudable goal of increasing goal of increasing insurance availability to employers of less than 100 employees, an employer group most likely to not provide an insurance program for their employees. He discussed purchasing cooperatives, noted other proposals; detailed survey responses collected by their Industry, giving results and statistical information. (See Attachment No. 9). (Opponent)

Sharon Huffman, Legislative Liaison for Kansas Commission on Disability Concerns (KCDC) presented testimony provided by Sharon Joseph, Chairperson. It was noted KCDC supports **HB 3075** as the best option that has been proposed thus far this session. She cited specific items they support in the measure, i.e., New Sec. 5(c),(d), New Sec. 10 (b) (1). Concerns expressed, i.e., **HB 3075** does noting to address the issue of universal coverage, or address the specific needs of people with disabilities. The Kansas Health Council should be made up of health consumers and health providers, and they propose the Council be expanded to five members with at least one of those members be representative of people with disabilities. (See Attachment No. 10). (Proponent)

Melville W. Gray, (Attachment No. 11), noted, there is duplication of effort with the proposals for the Health Council, and Health Care Cooperative, and he explained, noting the Cooperative is specifically prohibited from including consideration of medicare patients. This will "make homeless", for health insurance purposes, over 10,000 state retirees and spouses who are dependent on piggy-backing for supplemental coverage under state auspices. For many years the government and medical providers have preached "take charge of your own body", but in order to do that, he stated, we must be able to have freedom of choice of doctors whether or not they are within a HMO, alliance, or other artificial boundary, or out of state. He knows personally that self referral is often essential in making the difference between cure, near-cure, crippling, and even death. He noted it must be easier to make bureaucratic decisions in these matters when it is not your own life in question. Passage of comprehensive health care legislation is a staggering task and should not be undertaken lightly. A plan for the young is a severe responsibility, a plan for "old people" is virtually impossible when being developed by a young, healthy, bureaucrat. This effort will influence Kansas health care for years, so should not be made in haste nor without careful deliberation. He urged **SB 3075** not be passed in the present form. (Opponent)

Jim DeHoff, Executive Secretary, Kansas AFL-CIO, offered hand-out (Attachment No. 12), stated support, and requested amendments, i.e., Sec. 9A, line 15, item 4, to add a Kansas AFL-CIO representative, and possibly a Chamber of Commerce and Industry representative, because there are 95,000 members with health and welfare programs that are in place because of negotiated contracts. He stated, their membership has the expertise and experience to be an active participant with the Health Care Purchasing Cooperative. He urged passage for **HB 3075.** (Proponent)

Larry Magill, Jr., Executive V.President, Kansas Association of Insurance Agents, (Attachment No. 13) We are opposed to single-payer health care plan and to a single state health insurance purchasing cooperative or alliance. Clearly this measure is intended to take Kansas down the road toward a single payer plan. Another commission is not a wise use of state resources. The duties for this commission are too broad, too vague, and constitute an extensive delegation of legislative authority. He expressed concerns, i.e., is opposed to the state entering the private health insurance business, which appears to be clearly the intent of **HB 3075**; concerns regarding new Sec. 13, and he asked, what is the definition of managed care? Concerns expressed with New Sec. 13, Sec. 4, 15, 16, 21. These new health service networks and alliance would not be subject to the guaranteed issue and renewable requirements, among numerous other items which he detailed. Nor, would there be a level playing field with insurers, he added. There is great concern regarding funding. It is premature for Kansas to act before Congress on this broad issue. Kansas is not an island, and we cannot afford to lose jobs and economic development to other states because of our health care system. (Opponent)

Michael R. Todd, Health Care Reform Coalition (Attachment No. 14), said, realizing that **HB 2699** probably is dead this session, they do support **HB 3075.** They propose the Health Council, outlined in Sec. 2 should be expanded to 5 members, with at least one being a representative of consumers not connected to providers or insurance companies. Sec. 6 , they would ask to ensure freedom of choice of provider; mandate an option for a fee-for-service plan. Sec. 10, they suggest all Kansans be included by January 1, 1998. Sec. 26, they ask that a mandate option for a fee-for-service plan. He asked for support. (Proponent)

Mike Oxford, Kansas Association of Centers for Independent Living, offered (Attachment No. 15). He asked members to please read his written testimony. He would use his time to voice some observations. He noted health care is rationed now, rationed by cost. He personally cannot get health care coverage as it doesn't cover his condition. He has only the insurance he can afford which isn't very good. People with disabilities are ill served in the current system. He noted the majority of the employees at Centers for Independent Living are persons with disabilities, so therefore most do not have good insurance coverage, and certainly not at an affordable cost. He stated, if you can provide plans for health care for people with disabilities, it would be a true litmus test because if you can get health care that works for them, you will have health care that works for everyone, young, old, healthy or not. (Proponent)

Edward Rowe, League of Woman Voters of Kansas, lobby corp. offered hand-out (Attachment No. 16) stated the first choice of the League was **HB 2699**. While it is not clear that **HB 3075** addresses all of the key points, it would establish a Kansas agency capable of responding quickly whenever federal legislation is passed. It is the hope of the League that the legislature will pass a Kansas health care bill this year, have it in place with people ready to work as soon as Congress acts on their program.

Fiscal note provided on **HB3075.** (See Attachment No. 17.)

Noted: Recorded as (Attachment No. 18 is written testimony from Dr. Robert C. Harder, Secretary of Department of Health and Environment. (Dr. Harder attended an Appropriations Budget meeting and could not be present to offer his testimony in person for **HB 3075.**) (Proponent)

Chair thanked all conferees for their consideration of one another in the short amount of time that was given to Committee this date for a meeting.

Chair adjourned the meeting at 2:00 p.m.

The next meeting is scheduled for ? , 1994. (This is most likely the last Committee meeting for 1994 Session.)

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE March 23, 94

NAME	ORGANIZATION	ADDRESS
Michael R. Todd	Health Care Reform Coalition	Lawrence
Sharon Huffman	KCDC	Topeka
JoAnn Stephens	KCFHC	Topeka
Glyvon Jennette	403 Commission / KAOM	Rossville
Barbara Brown	403 Commission	Lawrence
Ted Kay	" "	Topeka
Margaret Gordon	Oldest Women's League	Lawrence
Hilda Enoch	Douglas County Advocacy Council on Aging	Lawrence
Jim Hamilton	General Surgeon	Topeka
Jim Schwartz	KECH	Topeka
Jodie Ebert	Hein, Ebert & Weir	Topeka
Jim McCann	~~Topeka~~ AARP	Topeka
Gena McFarland	O.P. Chamber	Overland Park
Lyn Guthrie	Health Midwest	KC
D. Crose	Shawnee Mission Med Ctr	KC
Millie Walter	EDS	Topeka
Mike Oxford	Kansas Association of Centers for Independent Living	Topeka
Carolynn A. Parsons MD	Doctor of the Day KAFP	Kenexa
Walter W. Crockett	AARP	Lawrence
Paul E. Fleener	Kansas Farm Bureau	Manhattan
SHELBY SMITH	KPMA	Wichita
Chip Wheelen	Ks Medical Soc	Topeka
Jerry Slaughter	" " "	"

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE March 23, 97

NAME	ORGANIZATION	ADDRESS
John Holmgren	Health Care Consultant	2912 Arrowhead Topeka
Jim McHaffie	KS AFL-CIO	Topeka
Larry Magill	KS. Assn. of Ins Agts	"
Kathy Reardon	KS Assn for Medically Underserved	Topeka

TESTIMONY TO
HOUSE PUBLIC HEALTH & WELFARE COMMITTEE

on March 24, 1994

by
Board Members of the Kansas Commission on the Future of Health Care, Inc.
William R. Roy, Sr., M.D., J.D., Chair
Barbara J. Gibson
Myron Leinwetter, D.O.

As chairman of the Kansas Commission on the Future of Health Care, Inc., I am pleased to have the opportunity to address the members of the House Public Health and Welfare Committee. I'd like to make a few opening comments related to the background of the Commission and then let my fellow Commission members provide specific rationale as to why the Commission is in support of HB 3075.

Our Commission worked for 28 months, took time from busy schedules to meet for over 150 hours and attend some 58 community meetings. Commission members dedicated themselves to the task of creating a health care reform plan for our state because we believed it was of vital importance for all Kansans to have health care coverage which is affordable. Our belief has been echoed over and over as we engaged in dialogue with Kansas citizens across the state.

Commission members brought to the task a wide array of skills, knowledge and expertise. Seven of the eleven members were health professionals with many years of clinical experience which provided them with a unique depth of understanding obtained through a direct provider-patient relationship. We worked hard, but even more critical we were able to put aside political and philosophical differences and engaged in an open, honest, and healthy debate, one which explored an array of viable approaches to changing the health care system. Our debate and discussion of a full gambit of options ultimately resulted in the creation of the Kansas Specific Health Care Plan, which on a final vote was strongly supported by nine of the eleven Commission members.
Recognizing the extremely fluid nature of today's reform climate and aware of the significant impediments to taking state action before receiving federal directives we presented to the Joint Committee on Health Care Decisions for the 1990s a request for the introduction of a bill which would establish the Kansas Health Commission. We viewed this as a modest, but important first step toward achievement of real health care reform in our state. Much important preliminary work must be accomplished if our state is to be positioned favorably to accommodate and possibly influence federal reform efforts. Being a state who is proactive does not mean we are going to preempt federal action, it simply means we will be prepared and ready for such action, rather than a passive recipient of federal directives. HB 3075 incorporates the conceptual basis embodied in our original proposal.

I'd like now to introduce Barbara Gibson, a member of the Commission appointed by Representative Robert miller who at the time of the appointment was Minority Leader in the House.

P.H. & W.
3-23-94
Attm #1

Thank you for the opportunity to address the House Public Health and Welfare Committee. I plan to take a few minutes to highlight the key elements forming the rationale for the Commission's recommendation to establish a Kansas Health Commission as set forth in HB 2699 and now entitled a Health Council in HB 3075.

- The tasks which need to be accomplished to ready us for either adaptation to a federal reform initiative or the development of a state plan are highly technical in nature:

  Consideration of financing and delivery options
  Work cooperatively with relevant agencies and groups to develop an integrated health plan for all Kansans
  Monitor trends in health care spending
  Develop plans for health care cost containment
  Coordinate integration of other health care providers and clinics into the state health care system

The Commission attempted to create an entity which would devote it's time solely to accomplishment of needed tasks with members appointed who had the technical skills needed for the venture to be successful. This council would be able to carefully examine a broad range of options and develop thoughtful recommendations for the consideration of the Legislature.

- The majority of states who have passed health care reform legislation have adopted a model employing an independent agency assigned the myriad of tasks required prior to implementation.

The Commission carefully examined health care reform activity of the various states and conversed at length with states who had chosen to undertake comprehensive reform. Both Washington and Vermont have established administrative entities to accomplish these tasks and recommendations for such structures have also emerged in Iowa, North Carolina, Montana, and several other states. This is a mechanism which has worked well in Vermont, whose Health Care Authority has been in place for several years, providing some insulation from political pressure to engage in thorough deliberation on options.

- States that have been successful in health care reform endeavors have done so through bipartisan activity involving both the legislative and executive branches of government.

Appointments to the Council would be made by the Governor with Senate confirmation and no more than two of the three members could be from the same political party. In addition, the structure envisioned by the Commission would be accountable to both the Governor and the legislature for performance of specified tasks.

This provides a quick overview of what the Commission believes is the most appropriate mechanism to accomplish tasks requisite to health care reform.
I'd like to now introduce Dr. Myron Leinwetter, a family practice physician from Rossville who represented the Kansas Association of Osteopathic Medicine on the Commission.

P.H.+W
3-23-94
Attm. #1-2
pg 2 of 3

Thank you for the opportunity to address you today. I'd like to take a few minutes to explain why I think it's imperative that our state begin to seriously address health care reform and why I think it is vital that the machinery to do that be put in place this legislative session.

- This is a problem that affects thousands of Kansans and the incremental measures enacted thus far have not eliminated the problem.

The Commission heard repeatedly at town meetings and through written communication of Kansans in desperate situations. These were individuals not dissimilar to those of us in this room; a reporter in Salina who had a young son with disabilities requiring frequent physical therapy who could not leave his job to one which would allow him to support his family better, a young professional employed at the Garden City Community College whose wife had a heart defect and their health insurance was costing 40% of their monthly take-home pay, and countless others.

Everyday in my office, I encounter similar situations. People who just can't wait a decade for policymakers to enact comprehensive reform legislation. Action is needed now.

- Consistently state after state have identified a set of tasks that need to be undertaken to prepare for reform regardless of the particular direction selected

The Commission in requesting introduction of HB 2699 delineated what we believed were the tasks which must be accomplished initially so that we could be ready for federal health care reform directives or if the legislature would choose to endorse a state reform plan. Most of those same functions are also included in HB 3075. I believe that it is important to continue to work seriously on health care reform in our state and that the creation of the Kansas Health Council would be an important first step.

I'd like to express the appreciation of the 403 Commission in giving us an opportunity to convey our viewpoint on this.

P. H. + W
3-23-94
Attm #1-3
~~pg 3 of 3~~

K A N S A S

NFIB
National Federation of
Independent Business

Testimony of
Hal Hudson, State Director
National Federation of Independent Business

Before the
Kansas House Public Health and Welfare Committee

on House Bill 3075

Wednesday, March 23, 1994

Madame Chairperson and members of the Committee: Thank you for this opportunity to appear here today. My name is Hal Hudson, and I am State Director for the Kansas Chapter of National Federation of Independent Business (NFIB), the State's largest small-business advocacy group, with about 8,000 members who employ nearly 100,000 Kansans. The average number of employees is about 10, while only one percent of our members employ over 100.

NFIB legislative policy is not set by a board of directors. NFIB's position on legislative issues is determined by ballots, surveys and questionnaires, through which we ask our members directly for their opinion.

I am here today to oppose enactment of H.B. 3075, because, on our State Ballot for 1994, 87.2% of our members responding said they were opposed to a universal health care access plan run by the State of Kansas.

The principles embodied in this bill are too much, too soon. As drafted, H.B. 3075 seems to accept enactment of a sweeping national health care plan as fait accompli, and attempts to establish an arm of Kansas State government as the agency to administer that plan. It is too soon to know what may be coming out of Washington.

PHW
3-23-94
Attm #2

3601 S.W. 29th Street, Suite 107 · Topeka, Kansas 66614-2015 · 913-271-9449 · Fax 913-273-9200

The Guardian of Small Business for Fifty Years

One month ago I provided testimony to the Senate Public Health and Welfare Committee opposing enactment of S.B. 521, which even Dr. Harder conceded was not acceptable to the Legislature. H.B. 3075 seems to be an attempt to merge Dr. Harder's bill with Dr. Roy's H.B. 2699. This simply is not a good move for Kansas - certainly not at this time -- if ever.

Currently there are in excess of 110,000 small businesses in Kansas with 100 or less employees. These small business owners continue to be the job creators sustaining the Kansas economy. According to the Kansas Department of Commerce and Housing, 75 to 80% of all new jobs - thus all net jobs in Kansas are created by small business. This is happening at a time when larger businesses employing over 500 employees are showing a net loss of jobs.

Many Kansas small businesses are financially fragile. Any government-imposed added costs, whether in the form of insurance premiums or payroll taxes, could force them out of existence. Others could be forced to cut back on jobs, wages of employees, or existing benefits.

We have no idea what the fiscal note for H.B. 3075 might be, and we doubt that you know. However, there will be a cost to set up the state bureaucracy, and that cost will be paid, either through insurance premiums or additional taxes. We do not need either.

In the hope that you will not label NFIB members as "aginers", let me assure that our members, both in Kansas and nationally, want to see reform. While NFIB members support health care proposals which will make access to health insurance cheaper and easier to obtain, they believe that health care reform must not destroy jobs.

Here's what NFIB members support:

* Creating voluntary health insurance purchasing groups.
* Enacting medical malpractice reforms to reduce lawsuits and the number of needless tests doctors feel they must perform to avoid lawsuits.
* Increasing personal responsibility for their health insurance and health care.
* Providing universal access to health insurance.

H, H, & W.
3-23-94
Attm # 2-2
~~pg 2 of 5~~

* Reducing the paperwork burden for small business owners.
* Implementing insurance reforms that limit the preexisting condition exclusion, guarantee the renewal of policies and establish fairer rating systems.
* Enacting legislation that gives self-employed business owners a 100% deduction for health insurance premiums.

NFIB Members oppose:

* Mandating employers to pay for health insurance for all their employees, including part-time and Medicare-eligible employees.
* Increasing payroll taxes.
* Setting government caps on private and public spending for health care.
* Enacting a government-based health care plan.

NFIB members, and the NFIB Washington staff, are encouraging Congress to adopt incremental reforms which will improve access and lower costs of health care and insurance, without establishing a giant government bureaucracy, and without mandates on employers. Many members of the U.S. Senate and House support these principles, and this approach to reform.

Our hope is that the Kansas Legislature also would support these concepts, and wait until Congress acts before enacting sweeping legislation such as H.B. 3075. Therefore, we urge you to report H.B. 3075 unfavorably.

Thank you. I will stand for questions at the pleasure of the chair.

P. H. + W.
3-23-94
Attm #2-3
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ABOUT NFIB/KANSAS

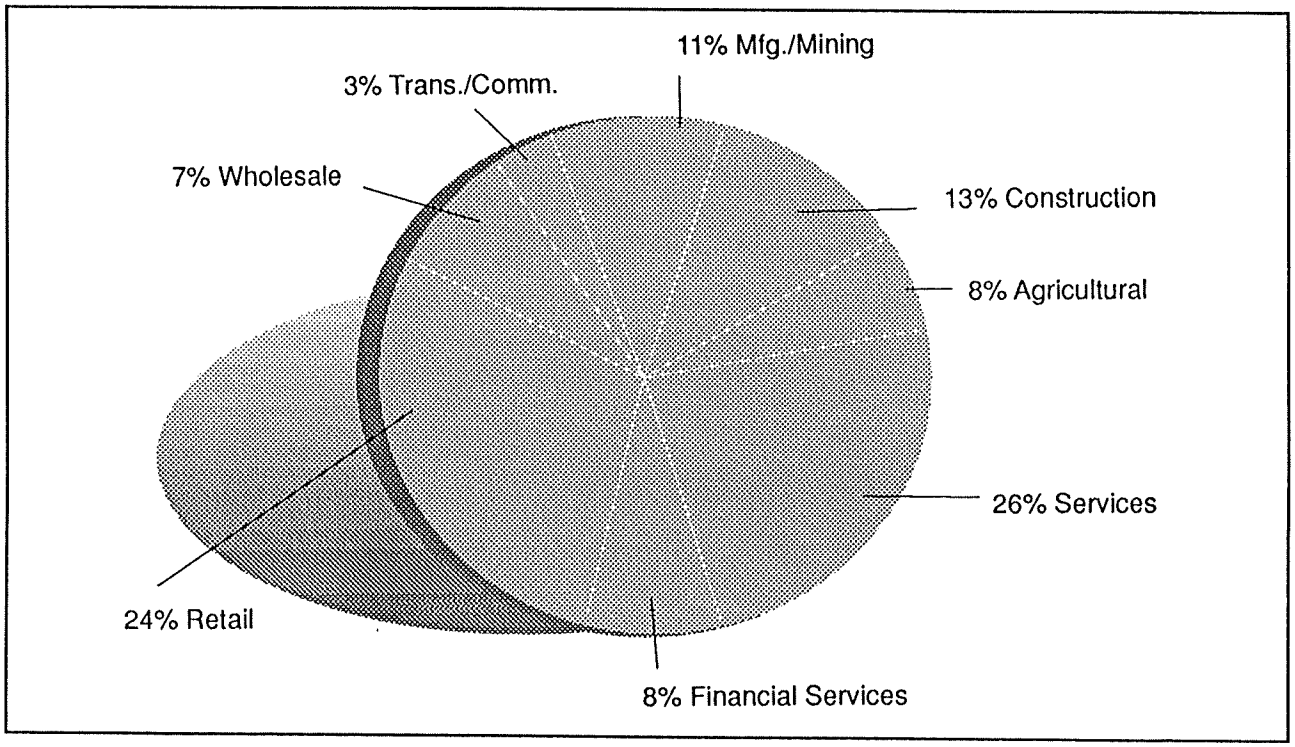
With nearly 8,000 members, the Topeka-based National Federation of Independent Business/Kansas is the state's largest small-business advocacy organization. Independent-business owners join the federation to have a greater say in the crafting of legislation and regulations that affect their lives and livelihoods.

NFIB/Kansas draws its members from all walks of commercial life: from family farmers to neighborhood retailers, from independent manufacturers to doctors and lawers, from wholesalers to janitorial service firms.

Each year NFIB/Kansas polls its diverse membership on a variety of issues. The federation uses the poll results to form its legislative agenda, aggressively lobbying in support of positions approved by majority vote.

Because policy is determined by direct vote of the membership rather than by a steering committee or board of directors, NFIB/Kansas lobbyists have exceptional credibility as spokespersons for the entire small-business community. Rather than represent the narrow interests of any particular industry or trade group, NFIB/Kansas promotes the consensus view of small-and independent-business owners from throughout the state.

NFIB/KANSAS MEMBERSHIP
by Industry Classification



NFIB Federal Legislative Office
600 Maryland Ave. Sw, Ste. 700
Washington, DC 20024
(202) 554-9000

3601 S.W. 29th St.
Ste. 107
Topeka, KS 66614
(913) 271-9449

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53 Century Blvd., Suite 205
Nashville, TN 37214
(615) 872-5300

NFIB
National Federation of Independent Business

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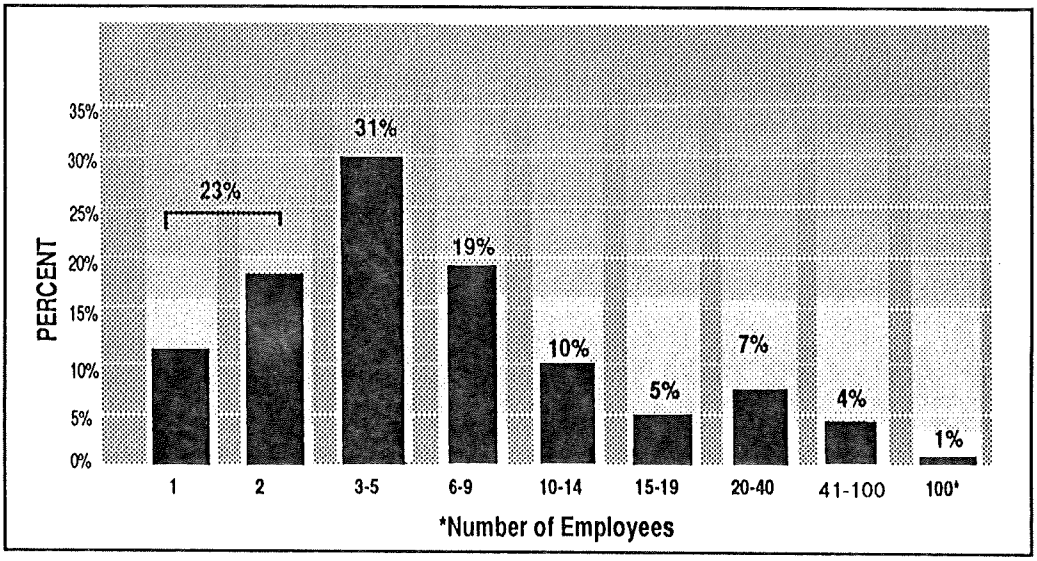
NFIB/Kansas Membership Profile

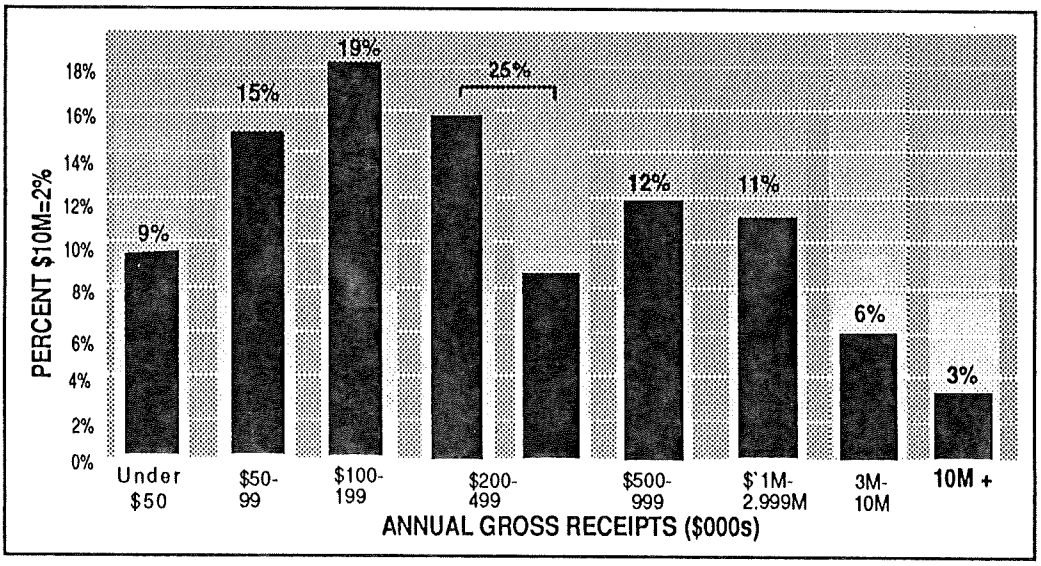
NFIB/Kansas represents the entire spectrum of independent business, from one-person "cottage" operations to quite substantial enterprises.

The typical NFIB/Kansas member employs five workers and rings up gross sales of about $270,000 per year. In aggregate, the organization's members employ nearly 92,000 workers.

NFIB/Kansas Membership by Number of Employees



NFIB/Kansas Membership by Annual Gross Receipts



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PUBLIC POLICY STATEMENT

HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

RE: H.B. 3075 - Establishing the Kansas Health Council and the Kansas Health Care Purchasing Cooperative

March 23, 1994
Topeka, Kansas

Presented by:
Paul E. Fleener, Director
Public Affairs Division
Kansas Farm Bureau

Chairperson Flower and members of the committee:

We welcome the opportunity to make some brief comments concerning H.B. 3075. Certainly every member of this committee knows that Kansans - and many of the organizations in this state from whom you hear on a daily basis - are interested in health care reform. The farmers and ranchers of this state who are members of Farm Bureau in the 105 counties of Kansas are no different. We have a strong and very thoughtful policy position on rural health care. It is attached to our statement.

For the record, my name is Paul E. Fleener. I am the Director of Public Affairs for Kansas Farm Bureau. We thank you for the opportunity to comment briefly on H.B. 3075. We come to you as an opponent of this particular measure, not because it does not have some worthy objectives. We will itemize some things for you contained in the legislation that are common goals for Kansans. We state our opposition because this legislation is not timely, does not contain

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ficient legislative involvement through existing Public Health an Welfare Committees, and because it presupposes or steps out in front of the debate on health care reform in the Congress of the United States.

Chairperson Flower ... members of the committee ... H.B. 3075 creates several layers of bureaucracy. It would first establish (in New Sec. 2) the Kansas Health Council. That would be a three member body being appointed by the Governor to do a number of things which are itemized in New Sec. 5. It is our thought that much of what is described in that section as "duties of the Council" are items which either are or should be undertaken by House and Senate Committees on Public Health and Welfare. Certainly all of the plans under consideration in Washington, D.C. contemplate interaction between State and Federal Government involvement in health care delivery. Certainly health care financing and delivery options are under consideration. Most certainly the state of Kansas should work cooperatively with relevant state and federal agencies, providers and consumer groups to develop an integrated health plan for all Kansans.

This legislature has contemplated and has enacted from time to time prudent legislation to deal with tort reform for medical liability. We are seeking the same thing at the federal level. This state has examined, previously, health care cost containment. That examination should continue within the legislative process.

In our reading of H.B. 3075 the numerous levels of bureaucracy and advisory committee appointments are within a framework that is top-down as opposed to an outreach from the legislature for inclusion of the various publics. What we are saying is that all of the groups created under H.B. 3075 would be under the sole control of the Governor and the look of the council, the look of the advisory

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mittees and the staffing pattern for all levels of this legislatic would change or could change following each gubernatorial election.

Probably as importantly as any point we could bring to you today is this: H.B. 3075 seeks to bring a solution to problems which are somewhat closer to being resolved through the federal examination of health care reform. We believe it is quite likely that with all of the new councils, advisory committees, boards and programs created by this legislation there would be a greater cost than the savings those councils, boards, and committees might recommend.

In conclusion let me point to two or three of the items in our Farm Bureau policy position:

Health care is primarily the responsibility of the individual. Health care policy changes should endorse the following principles:

1. **Promotion of personal wellness ~~fitness~~, fitness and preventive care as basic health goals;**
2. **Minimal government intervention in decisions between providers and receivers of health care;**
3. **Federal tax policies that encourage individuals to prepare for future health care needs.**

Following those points in our resolution or policy position you will find an itemization of steps our farmers and ranchers believe would assist in preserving health care for rural Kansans ... indeed for Kansans wherever situated.

Thank you very much for consideration of our views on H.B. 3075 and the very important topic of health care reform.

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This resolution was adopted by the Voting Delegates at the 1993 Annual Meeting of Kansas Farm Bureau, November 18-20.

Rural Health Care **PHW-4**

Access to high quality and affordable health care is essential to all Kansans. Access and affordability will not be achieved by mandating employers to pay health insurance costs for employees, nor by enacting a single-payer, government-based health care plan.

Health care is primarily the responsibility of the individual. Health care policy changes should endorse the following principles:

1. Promotion of personal wellness, fitness and preventive care as basic health goals;
2. Minimal government intervention in decisions between providers and receivers of health care; and
3. Federal tax policies that encourage individuals to prepare for future health care needs.

We support the following measures which will assist in preserving this vital service to rural Kansas:

1. Reduce the shortage of rural health care professionals by encouraging students to enter the health care professions, serve residencies in rural areas, establish and maintain practice in rural areas. Providers in urban areas should be encouraged and given incentives to participate in respite, locum tenens and sabbatical programs for rural physicians;
2. Create and/or maintain state scholarship programs for all health care professionals, require scholarship recipient graduates to provide some service in underserved areas, and create a strong disincentive for any scholarship recipient "buying out" of that required service;
3. Encourage the Legislature and Congress to expedite visas for foreign doctors who are qualified, willing to work in rural areas, and sponsored by a rural hospital or clinic;
4. Programs which implement joint use and cooperation between and among health care facilities, school districts, municipal and county governments to enhance health education, preventive health care, and efficiency of health car delivery;
5. Establish innovative managed care programs through incentives for government, providers and private insurers where medical services are offered through a network of physicians and hospitals at discounted costs; and
6. Authorization and support by the Kansas Board of Regents for Kansas State University/University of Kansas School of Medicine (Kansas City and Wichita) for the joint effort underway to develop the Rural Health Dynamics Program.

In order to provide affordable health insurance coverage to all Kansans, we encourage consideration of the concept of "community based health insurance rates." If the insurance industry continues to use a review of health care utilization as a method of establishing rate increases in Kansas it should use a running average to establish rates.

We believe the financial stability of some hospitals is being threatened by the increasing number of non-paying patients. We will support the following:

1. Amend state law to allow hospitals greater access to small claims courts so they may collect more debts from those who can pay;
2. Establish a statewide risk pool for those who cannot access health insurance due to pre-existing conditions; and
3. Change the health care coverage rules to make preventive care as well as emergency care available to the medically needy.

Denial of claims for pre-existing conditions, once an individual has been covered by insurance, changes jobs, or has filed a claim for such condition, should be prohibited.

For many of our elderly, nursing home care will be a necessity. For others, remaining in their own homes will be far preferable. We believe health care programs for senior citizens in Kansas should maximize the independence of the elderly for as long as possible. Development of local Home Health Care organizations would assist both affordability and availability of health care. The Kansas Legislature should provide more flexibility in the allocation of per diem rates for nursing staff.

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KMS
KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

March 23, 1994

To: House Public Health and Welfare Committee

From: Jerry Slaughter
Executive Director

Subject: HB 3075; Concerning the Kansas Health Council

The Kansas Medical Society appreciates the opportunity to appear today as you consider HB 3075, which would establish the Kansas Health Council, and expand the responsibilities of the Kansas State Employees Health Care Commission (renamed as the Kansas Health Care Purchasing Cooperative).

In view of your action yesterday on SB 816, we are uncertain of the status of HB 3075. However, at the outset, let me make it clear that KMS is ready and willing to work with whatever entity is charged with the responsibility of directing health system reform activity in the coming years. We support a collaborative approach that involves interested groups, including health care providers, in the fundamental discussions about how the system will be changed.

To review briefly our position on health system reform, we believe the following should be a part of any comprehensive plan which is eventually adopted:

1. Universal coverage, with financial responsibility shared among individuals, employers and government.

2. Support for programs to train and maintain an adequate supply of primary care physicians in order to improve access to care in underserved areas.

3. Freedom for patients to select the physician and health plan of their choice.

4. Competition in the marketplace to slow the increased rate of health care spending.

5. Elimination of needless bureaucracy and administrative costs.

6. Keeping medical decision-making in the hands of physicians and patients, and protecting that relationship from the spreading dominance of corporate and government intrusion.

7. Remove antitrust barriers so physicians can work together to develop competitive and cost-effective health plans.

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When this committee held hearings on SB 816 one week ago, we said that the Legislature should continue to work on those things that are within our state's ability to effect, irrespective of federal action. There are bills moving through the process which will keep Kansas going the right direction on health system reform. Not everyone will agree on the speed and breadth of reform, but the important point is to keep working on sensible and responsible system improvements. We also cautioned the committee on being too anxious to be a "fast-track" state, implementing sweeping reforms before Congress acts. Many of the states that enacted ambitious reform plans are now having to delay their programs or substantially pull back because they are finding that it is more complex and expensive than they imagined.

As to HB 3075, we would like to commend the Governor for taking an active interest in the health system reform debate. We have said earlier that her Department of Health and Environment, and Secretary Harder in particular, should also be commended for efforts to advance the debate.

Fundamentally, the provisions in HB 3075 which establish the Kansas Health Council are quite similar to those contained in SB 816, which sets up the Health Care Reform Legislative Oversight Committee. As a practical matter, both bills set up a nearly identical process to continue the reform debate except for one substantial difference: the Council in HB 3075 is made up of three salaried individuals appointed by the Governor (presumably non-legislators); and the Committee in SB 816 is made up of ten legislators. This difference is significant. (We should also note that we have no position on how the legislative composition of the Oversight Committee in SB 816 should be apportioned.)

The key, early decisions affecting health system reform will almost certainly involve tax policy and mandates of some kind. These are decisions that can only be made by the Legislature, since they are policymaking in nature. If the Legislature is to be responsible for establishing policy, it would seem to make sense to involve legislators in the process which is going to be designing the system reform plan. If they do not have a significant role in that process, there will not be a sense of "ownership" for the final product, a reality that cannot be denied. Further, it is unrealistic to expect the Legislature to delegate legislative functions to an executive branch agency. That is not to say that the concept of an ongoing committee or council of some kind is not appropriate. However, its role should be to implement policy, not make it. Perhaps the concept in HB 3075 will be the appropriate mechanism for implementing health reform policy once the Legislature acts next year, but for now it is premature.

We stand ready to participate in the discussions which will result in responsible reform of our health system, in whatever structure the Legislature ultimately chooses. Thank you for considering our comments on this important issue.

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TESTIMONY ON H.B. 3075, TO ESTABLISH THE KANSAS HEALTH COUNCIL

AND THE KANSAS HEALTH CARE PURCHASING COOPERATIVE

Walter H. Crockett, Kansas AARP, March 23, 1994

Kansas AARP has already supported, with deep reservations, S.B. 816 to establish a Health Care Reform Legislative Oversight Committee. Our reservations concerned the failure of this bill to move the state toward a clear program of health care reform in the reasonably near future. We have the same reservations about the present bill. However, since either this bill or S.B. 816 are the best we are likely to get at this time, we have examined the two bills to determine which is most likely to achieve real health care reform. We find positive aspects in each; therefore, we suggest that this Committee combine the best aspects of the two bills and report favorably a merged bill to the House of Representatives.

First, let me emphasize the nonpartisan nature of Kansas AARP. We take no sides in the contest between political parties. Members of the Long-Term Care Action Committee of Kansas AARP, of the State Legislative Committee, the Capitol City Task Force, AARP Vote, and other, related committees are not chosen for their political allegiance. Given the political make-up of the Kansas population, I assume the committees have more Republicans than Democrats, but I do not know to which party any individual member belongs and I hope they do not know mine. We are united by our commitment to health care reform, not by political preference. As a result, we approached the comparison of S.B. 816 and H.B. 3075, not in terms of which political party advocates them, but in terms of their promise to move the state toward universal coverage for health care.

These two bills assign remarkably similar duties to the bodies they create. The duties are to examine developments in health care reform at the federal level, to develop plans to merge our state into the national program, and to coordinate our actions with those of neighboring states. The bills differ chiefly in how they would accomplish these goals.

The chief advantage of S.B. 816 is that it involves legislators directly in these activities. There is a great deal to say for having the legislature immediately involved in monitoring federal actions, in studying the state's health care needs, and in drafting the bills that will eventually emerge. But we doubt that a ten-member legislative committee can effectively coordinate the work that would be required. The duties include monitoring what goes on at the federal level, judging how this meshes with present Kansas laws, cooperating with federal agencies, examining options for financing and delivering health care, developing an integrated health plan, analyzing health care data for the state, developing plans for cost containment, integrating Kansas plans with those of others states, determining how to improve health care delivery in underserved areas, and so on. To accomplish these duties effectively, someone needs to keep abreast of what is happening with respect to each one, to communicate between various sub-committees and coordinate their actions, so that the state can deal quickly and effectively with developments at the federal level.

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I doubt that members of this committee need to be told that a legislator must deal with many other problems than health care reform. It seems unreasonable to expect a group of ten legislators to handle effectively these coordinating actions. Someone needs to be responsible for doing them. For Kansas AARP, like everyone else, the prospect of bureaucrats establishing tables of organization, writing memos, and shuffling papers has the same effect on our spine as squeaking chalk on a blackboard. But we have quite a different reaction to the vision of administrators keeping on top of issues, making sure that everyone is informed of what is going on, coordinating activities, and dealing with disagreements and hurt feelings tactfully and effectively. H.B. 3075 provides at least the possibility, not of bureaucracy run wild but of effective administration. We do not know whether as many administrators are required as this bill provides: a three member council, an executive director, and other employees as necessary. However, we do urge this committee to combine the legislative representation envisioned in S.B. 816 (perhaps with fewer than 10 members) with an administrative structure like that proposed in H.B. 3075. The legislators can then be responsible for making sure that the administrators are effective.

Beyond this, we think it is essential for this legislation to commit our state to specific deadlines for accomplishing aspects of health care reform. H.B. 3075 does so. It requires a progress report from the Kansas Health Council within one year. Within three years, the Council is to produce a proposal for bringing employees of small businesses into the health care purchasing agency that presently serves state employees. Within four years, the Council is required to prepare a proposal that will enroll Kansas in a federal program for health care reform. This timetable does not commit the state to a single-payer system of health care, or to a managed care system, or to employer mandates, or to any of the other developments that are being proposed in the national debate over health care. Decisions about the form of the system we will take and how it will be financed are left to be worked out in the future. But the deadlines do commit the state to making essential decisions about health care reform within a defined and reasonable time frame. We think such a commitment is imperative.

On behalf of Kansas AARP, then, I urge this committee to merge S.B. 816 and H.B. 3075 by (1) combining legislative representation on a council or commission with an effective administrative structure and (2) establishing a reasonable timetable for the development of health care reform in Kansas.

Thank you for this opportunity to address the committee.

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DERMATOLOGY, P.A.
Robert D. Durst, Jr., M.D.
1706 West 10th Street
Topeka, KS. 66604
(913)357-5166

MEMORANDUM - March 23, 1994

TO: House Public Health & Welfare Committee
STATE OF KANSAS
State House
Topeka, Kansas 66612

FROM: Robert D. Durst, Jr., M.D.

SUBJECT: HB3075

Dear Representative Flower and members of the Committee:

I have practiced medicine for the past 25 years, 21 of those years as a dermatologist here in Topeka, KS. I have been active in my county and state medical societies and was privileged to serve two terms as President of the Shawnee County Medical Society. I am here today representing myself and many other physicians who feel as I do.

I have worked under medicare and medicaid, two government regulated systems. I have worked under three other government regulated systems: 1) the VA system, 2) the Louisiana state system of Charity Hospitals, and 3) New York City's Health and Hospital system. These highly regulated and bureaucratized systems did not always serve the patients well, and often were not cost effective.

There are difficult problems in our present health care system both in Kansas and our nation. Most significantly, increasing health care costs and an alarming and evergrowing number of people who have no health insurance. I deeply appreciate Governor Finney's efforts to bring medical reform to the "front burner" in our state by introducing HB3075 and HB3076 to the legislature.

A great debate rages in our nation regarding health care reform. Reform issues are crystallizing into two very different and opposing philosophies. One side feels that we need greater governmental intervention, with more controls, more rules and regulations, and more surveillance powers, to control costs. This approach is what I call "control from the top down", which minimizes the role of individual patient responsibility. The second approach attempts to empower people, the patients who receive medical services, with incentives to act more responsibly in controlling health care costs by lifestyle modification. The second approach believes the individual will make the best choices

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if given incentives and responsibility in a free market system.

Will the health care industry be more productive, efficient, and less costly if we impose strict regulatory controls, or would it be best to de-regulate it as we have done with other industries such as in trucking and the airlines.

The Problem:
Seventy-seven percent of health care expenses are directly paid by someone other than the patient. Ninety-five percent of hospital costs and eighty-two percent of physician costs also fall within this category. Government accounts for 43 percent of all health care expenditures, while private insurance covers 43 percent.

Since World War II, the American health care system has been shaped and molded by government policies that range from: wartime wage and price controls, which generated the current employer based system of health insurance; to federal tax codes which financially benefit employers who offer health insurance while discriminating against the self-employed; to the Medicare and Medicaid entitlements which have fueled the huge spending increases in health care at both the state and federal level. During the past 20 years hundreds of mandates have been passed in the state legislatures and it is estimated that they account for 25 to 30 percent of health care costs.

Much of the escalating, uncontrollable expense of our health care system has been created by governmental intervention. New policies are now being proposed which would return control to the individual. These policies would empower individuals to help solve the current health care dilemma. A significant proposal would establish medical saving accounts and allow individuals the same tax privilege of deducting their medical premiums that employers enjoy.

Two of five major proposals before the U.S. Congress employ the medical saving account plan as part of their legislation. There are Bills before the Kansas House recommending that Kansas adopt measures to establish medical savings plans, and to allow individuals to deduct their health premiums from their taxable income just as businesses do. Both of these measures empower individuals to act in a more responsible manner.

HB3075 calls for the creation of a three-member council which will be vested with significant authority to manage health care policies. This Bill assumes that the free market place for health care will further collapse and the system subjected to increased governmental policy and control. In fact, there is significant legislation on the state and national levels which would accomplish exactly the opposite effect. I feel it is premature for the Legislature to delegate their authority before the final form of health care reform is known and, because of this, must oppose HB3075.

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If power is money, then this Bill delegates more power to this three-member, non-elected, council than all of the elected state officials including the Governor, the members of the Kansas Senate and the House of Representatives combined.

Health Care comprises approximately one seventh of our nation's economy. The annual budget and the total health care budget for the State of Kansas equal approximately seven billion dollars, each. If you subtract the medicaid portion from the state budget and count it on the health care side, the total health care budget alone is greater than the entire budget for the State of Kansas (minus Medicaid) and all of the services the state provides, including schools, roads, welfare payments, etc.

Our nation became the most productive country in the world by encouraging individuals to maximize their own ability to produce and be rewarded for their productiveness. Power needs to be returned to the people. Every citizen must be empowered to:

1) prudently select their own health insurance
2) prudently consume health care resources
3) strive for a healthy lifestyle, so that each individual can continue to be productive and consume a minium of health care services.

Thank you, Representative Flower and members of the Committee for this opportunity to share my thoughts with you today.

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Health Care REFORM

Taking responsibility for personal health will cut costs

Dr. Robert Durst

Guest columnist

We are engaged in a national debate over health care reform, the ultimate goal being to solve the crisis created by spiraling medical costs. There are a multitude of issues which have been categorized under the generalized heading of "health care reform," all in need of discussion.

Key among these issues is the difference between "health care" and "medical care." The first addresses the continued wellness of a person not in need of acute medical care. The second focuses on providing someone with medical care to restore them to a healthy state or maximize his or her ability to function within the confines of their condition. In short, health care implies a state of wellness with action taken to maintain that state, and medical care implies actions taken to restore a person to a state of wellness.

Often, when what is really being spoken of is medical care, the term health care is substituted, which implies something completely different. Medical care is a single element of health care. Other elements include those necessary to maintain good health — proper nutrition, sufficient exercise, lifestyle choices and environmental health and safety standards. These factors, in the long term, are more important in maintaining health than medical care.

Eighty percent of all cancers are lifestyle related. Only about 10 percent of premature deaths in developed nations are due to inadequate medical care. The balance are due to unhealthy lifestyles (50 percent), environmental factors (20 percent) and genetics (20 percent). Our medical care system is in crisis today because we can no longer afford to pay for the quality and quantity of services delivered. How significantly would the cost of medical care be reduced if everyone wore a seat belt, consumed a low-fat diet, exercised regularly, didn't smoke or abuse alcohol and drugs?

American life expectancy at birth is 75.5 years, placing the United States 11th among the top 15 countries worldwide. Comparisons, made from post-adolescense and onward, put the United States at fourth place by age 65. Statistics are skewed by high rates of adolescent homicide, suicide, drug addiction, trauma and a high infant mortality rate.

The U.S. homicide rate for males ages 15 to 24 is 44 times higher than Japan's rate. Infant mortality rates are elevated by risk factors for births to women under age 18, including premature and low-birth-weight babies, the major causes of infant mortality. Thirteen percent of American mothers are teenagers, compared to 1 percent in Japan. The mortality rate of infants born to unwed mothers of all ages (26 percent greater than in Japan) is about 60 percent higher than those born to married mothers. Similarly, teen pregnancy rates in the United States are 2.5 times those of Canada and Britain. Worldwide, the incidence of low birth weight in the United States is higher than those of 31 other countries.

More than 90 percent of low-birth-weight infants are saved in America, which is more than any other country. Still, each year 40,000 babies cannot be saved. The costs of the medical care for these infants, combined with costs associated with trauma victims, substance abuse, etc., is staggering. Is it any wonder that our medical care costs are higher than other nations that we compare ourselves to? As a nation, we consume a higher percentage of fat in our diets than any other nation. Is it any wonder we lead the world in atherosclerosis, and that half of our population dies with heart attacks?

only when we individually and collectively assume responsibility for our health care will we be able to significantly reduce our medical care costs. Each of us must take responsibility to improve our health habits.

Health care system reform allows the nation to provide incentives to encourage everyone to accept responsibility for his or her health, and to make the changes necessary to become more healthy. If we are unwilling to assume responsibility for our health, we will be forced to increase taxes to fund a national health care system that will ration care under a bureaucratically administered, medical care global budget.

Robert Durst M.D. is a board certified dermatologist, past president of the Shawnee County Medical Society and a member of the board of directors. He is also a member of the Kansas Medical Society's Council and its FUTURE Task Force on Health Care.

This was published in the January 17th, 1994 Topeka Capital-Journal.

PHW
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attm # 6-B

PATIENT POWER

Prepared by Brink Lindsey, Cato Institute
Published by the American Council for Health Care Reform
Printed by the Cyril-Scott Company

"Giving people choices in health care and instilling cost-consciousness is plain old common sense. In Medical Savings Accounts, authors Goodman and Musgrave have hit upon a bold concept that may revolutionize the way health care is delivered throughout America."

—Sen. Phil Gramm

Our present health care system is suffering from runaway prices and spending. For the past three decades, health care spending has been growing more than twice as fast as the overall economy; as a percentage of gross national product, it has risen from 6 percent in 1965 to 14 percent today. Meanwhile, the system is plagued not only by overspending, but also by underinclusion: at any given time about 35 million Americans do not have health insurance. That combination of ills appears to pose an intractable problem: any move to extend health insurance in its current form to those without coverage will only fuel demand for health care and push spending up even further.

Fortunately, there is a solution to the predicament. The key is recognizing exactly what is driving spending through the roof. While many conditions have contributed to the spending explosion, one stands out as *the* fundamental problem with the U.S. health care system today: the consumer, the patient, has been cut out of the decisionmaking loop. Of every health care dollar spent in this country, 76 cents are paid by someone other than the actual patient—by the government, insurers, or employers. Consequently, in most situations patients neither benefit when they spend wisely nor bear the consequences of spending foolishly. With those incentives, it's no surprise that costs are soaring.

To reform the system we need to change the incentives. We need policies that will allow people to choose whether and how to *spend their own money* on health care needs. That is the idea behind the free-market approach to health care reform, which we call the Patient Power plan. The plan is explained in detail in *Patient Power: Solving America's Health Care Crisis* (Cato Institute,

1992) by John C. Goodman, president of the National Center for Policy Analysis, and Gerald L. Musgrave, president of Economics America, Inc.

Under the Patient Power plan, people would be able to switch from their current low-deductible health insurance policies to high-deductible catastrophic policies and put the premium savings in tax-free Medical Savings Accounts (MSAs). Those accounts would be used to pay ordinary and routine medical expenses, and catastrophic insurance would still be available to cover any major expenses. Whatever money was left in MSAs at the end of the year would remain there and continue to earn interest—you would get to keep what you didn't spend.

The Patient Power plan would give people a direct financial incentive to spend prudently on health care, because they would be spending their own money. Furthermore, Patient Power would extend the same tax advantages to all Americans, unlike the current system that discriminates against the unemployed, the self-employed, and employees of small businesses that don't offer health insurance. Ensuring tax fairness would go a long way toward making

To reform the system we need to change the incentives. We need policies that will allow people to choose whether and how to spend their own money on health care needs.

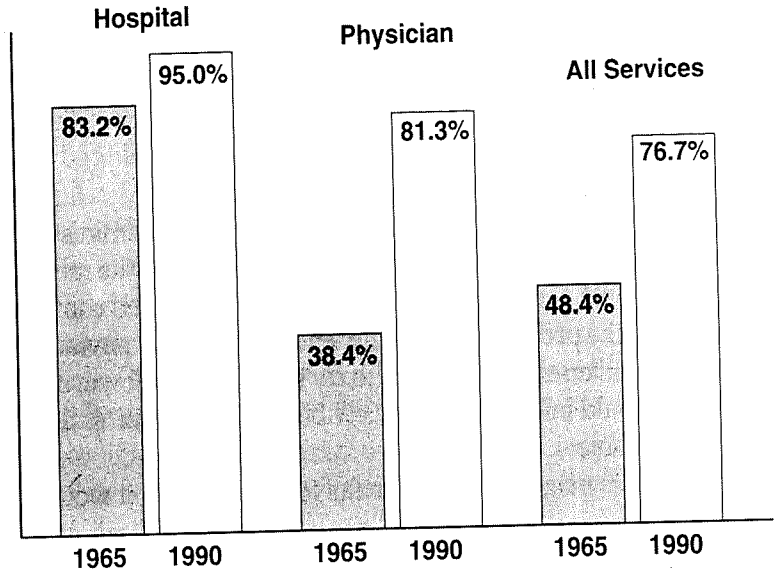
health care affordable for people who are now without health insurance.

The Patient Power plan is explicitly voluntary: it is not designed to compel universal coverage under some one-size-fits-all arrangement. The most basic element of a truly competitive health care system is to allow people the freedom of opting out of it—true patient power begins with that fundamental freedom of choice. Accordingly, the Patient Power plan strives to expand options, not foreclose them—to let people make up their own minds about what works best for them.

The Rise of Third-Party Payment

Before 1965 spending on health care was restrained by the fact that most payments were made out-of-pocket by patients. Since then Medicare and

Figure 1
Percentage of Personal Health Expenses Paid by Third Parties, 1965 and 1990



Source: *Patient Power.*

Medicaid have expanded government third-party insurance to more and more services for the elderly and the poor, and private health insurance has expanded for the working population. As Figure 1 shows, 95 percent of the money Americans now spend on hospitals is someone else's money at the time it is spent. Some 81 percent of all physicians' payments are now made with other people's money, as are 76 percent of all medical payments for all purposes.

Third-party payment is now so dominant that the term health insurance has become a misnomer. True insurance is supposed to protect people against losses from rare high-cost events. Today's health insurance, however, covers all kinds of routine expenses that are entirely under the patient's control; such coverage is less insurance than prepayment of medical services. Auto insurance doesn't cover fill-ups and oil changes, but today's health insurance covers the equivalent.

As a result of the dramatic rise of third-party payment, the consumers of health care, the patients, no longer have much incentive to spend money wisely. When people pay only five cents on the dollar for hospitalization, they are

ikely to be very prudent consumers, and hospitals are under little pressure to offer good deals. Elementary economics teaches that as prices go down, demand increases, and the recent history of the U.S. health care system confirms that basic truth. Because of third-party payment, health care has become nearly free at the point of sale, triggering an explosion in spending.

Putting Patients Back in Control

The health care reform proposals favored by the Clinton administration do nothing to address the third-party payment problem that is the root of the health care crisis. In fact, the administration's plan for "managed competition" would worsen the problem by creating a new third-party payment system that would be universal in coverage. To try to keep costs down, managed competition would impose onerous new bureaucratic controls and limitations on patients' choices.

Not only would managed competition fail to control costs, it would also pose a serious threat to the continued quality of American medical care.

In Britain kidney dialysis is generally denied to patients older than 55, causing at least 1,500 people to die every year for lack of dialysis.

Managed competition means greater bureaucratic rationing of health care—whether openly through price controls and expenditure limits (so-called global budgets) or less obviously through increased third-party control over what services are paid for. But whatever form it takes, bureaucratic rationing means lower quality care. Just look at what has happened in countries where government controls the health care purse strings. In Britain kidney dialysis is generally denied to patients older than 55, causing at least 1,500 people to die every year for lack of dialysis. In Sweden the wait for heart x-rays is more than 11 months. And surgeons in Canada report that, for patients in need of heart surgery, the danger of dying on the waiting list now exceeds the danger of dying on the operating table.

The Patient Power plan rejects the bureaucratic approach of managed ıpetition. Combatting artificially stimulated demand with top-down

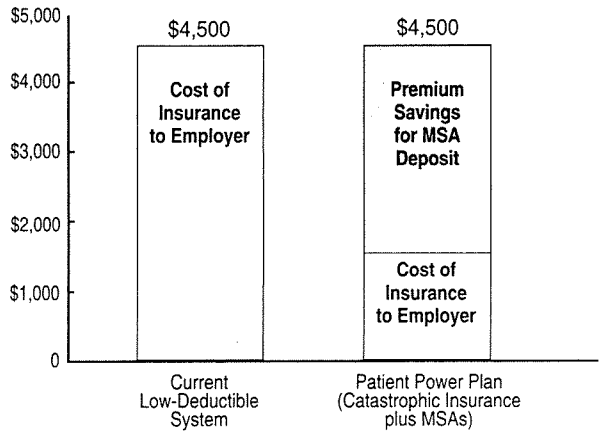
bureaucratic interference is a multiplication of mistakes. The result is higher costs *and* lower quality care. What we need instead is a system that controls demand at the source: the individual patient. The way to get individual patients to control demand is to give them a financial incentive to do so.

Supplying that financial incentive is what the Patient Power proposal for Medical Savings Accounts is all about. Under the Patient Power plan, people would be able to deposit up to a certain amount of money every year in tax-free MSAs. Most people would fund their accounts by switching from their current low-deductible health insurance policies to high-deductible catastrophic policies and depositing the premium savings. They would then be able to draw down their account balances to pay ordinary, routine medical expenses, such as doctor's office visits, prescription drugs, diagnostic tests, and minor procedures. Catastrophic insurance would still cover the big-ticket items.

Whatever money you didn't spend during the year would remain in your MSA to build up tax-free interest over time. Most people would be able to accumulate substantial savings over their working lives, which they could use upon retirement for whatever medical or nonmedical purpose they chose.

Patient Power is thus diametrically opposed to the Clinton administration's managed-competition approach. Managed competition seeks to reform the health care system by adding new layers of bureaucratic control

Figure 2
Typical Health Insurance Costs in a City with Average Cost of Living



Source: Golden Rule Insurance Company.

d further restricting consumer choice. Patient Power does just the opposite: it seeks to strip away third-party-payment bureaucracy and expand consumer choice. That is why we call this proposal Patient Power: the goal is to empower patients, not bureaucrats.

How Medical Savings Accounts Would Work

Figure 2 gives an indication of how Patient Power would operate in practice. In a city that has an average cost of living—say Cincinnati or Denver—employers pay roughly $4,500 a year to provide an employee and his family with health insurance coverage. The policy has a low deductible, typically from $100 to $250. By contrast, the premium for a catastrophic policy with a $3,000 deductible is only about $1,500 a year. Under the Patient Power plan, an employer could provide a catastrophic policy and then put the $3,000 in premium savings in the employee's MSA. The employer is out $4,500 either way; it makes no difference to him how the money is split up. But for the employee, the advantages of the switch are enormous: he actually gets more money in cash (tax-free, interest-bearing cash) than he loses in reduced insurance coverage—even during the first year. Over time unused savings continue to build up with tax-free compound interest.

The vast majority of Americans would greatly benefit from the combination of less expensive high-deductible policies and Medical Savings Accounts. In any given year most Americans have no or very small med-

The vast majority of Americans would greatly benefit from the combination of less expensive high-deductible policies and Medical Savings Accounts.

ical expenses, and 94 percent have medical expenses under $3,000. Under such a system, your maximum personal exposure every year is capped by your catastrophic policy; meanwhile, your savings to meet that possible exposure keep accumulating every year with interest. In other words, the :k is stacked in favor of your coming out ahead.

Medical Savings Accounts would be of particular help to employees

and their families when money was tight. Even today's low deductibles, particularly when combined with copayments, can create true hardship for those struggling to make ends meet. With an MSA, money would be available to pay the *first dollar of medical costs*—no deductibles, no copayments. In addition, people who were between jobs could use their MSAs to buy insurance coverage. About half the people who are uninsured remain that

Under current law, employers spend pre-tax dollars on health care; everyone else is forced to spend (for the most part) post-tax dollars.

way for four months or less; typically, they are between jobs that provide them with health insurance benefits. The accumulated savings in Medical Savings Accounts would be available to tide people over during such times.

Establishing Tax Fairness

If Medical Savings Accounts are as great as they sound, why haven't employers made them available already? Why don't employers offer high-deductible policies and cash bonuses as an alternative to conventional low-deductible insurance?

The reason such arrangements are currently unattractive is that under existing tax laws, only the *employer's* spending on health care is fully tax-deductible. Today, all the money an employer spends on health insurance for employees is tax-deductible; furthermore, none of it is included in the employee's taxable income. By contrast, self-employed people can deduct, at best, only 25 percent of their health insurance expenses—and even that limited deduction is not a permanent part of the law; it is on-again, off-again from year to year depending on whether Congress reauthorizes it. And the unemployed and employees of small businesses that don't offer health insurance get no deduction at all when they try to purchase insurance on their own.

Thus, under current law, employers spend pre-tax dollars on health care; everyone else is forced to spend (for the most part) post-tax dollars. The tax bias in favor of employer-provided health insurance is considerable. As Table 1 indicates, a dollar of pre-tax health insurance benefits can be worth almost two dollars of taxable salary. Accordingly, once filtered through the various tax

ectors, the premium savings from switching to a high-deductible policy ...ould shrink as much as 50 percent if they were given as cash to employees. And if employees tried to establish their own make-do Medical Savings Accounts with that post-tax money, they would also have to pay taxes on the interest they earned. It is little wonder that employers and employees opt for the tax-favored benefit over the tax-discouraged one.

It should be noted that under the current system, some people covered by employer-provided insurance are able to earmark money to go into so-called flexible savings accounts, from which they can pay health expenses with pre-tax dollars. The problem with flexible spending accounts is that at the end of the year, any unspent money reverts to the employer. That "use it or lose it" approach obviously encourages wasteful spending—the opposite of what Medical Savings Accounts would do.

The bias in the tax system not only discourages self-insurance through medical savings, it also renders conventional health insurance unaffordable for many Americans. The self-employed, the unemployed, and employees of many small businesses must pay post-tax dollars for their health insurance, and not surprisingly they rarely do. About 90 percent of Americans who have private health insurance get it through their employers. Those not lucky enough to qualify for tax advantages through their employers must fend for themselves, and their numbers swell the ranks of the 35 million uninsured.

The present indefensible system came about, strangely enough, because of wage and price controls during World War II. Businesses tried to get around

Table 1
Relative Value of a Dollar of Employer-Provided Health Insurance Benefits

Federal Tax Category[1]	Value with No State and Local Income Tax	Value with State and Local Income Tax
FICA tax only	$1.18	$1.24[2]
FICA tax plus 15 percent income tax	$1.43	$1.57[3]
FICA tax plus 28 percent income tax	$1.76	$1.97[3]

Source: *Patient Power.*

[1] Includes employer's share of FICA taxes.

[2] State and local income tax rate equals 4 percent.

[3] State and local income tax rate equals 6 percent.

wage freezes by offering health insurance benefits to their employees. The Internal Revenue Service went along, granting them a tax deduction and excluding the fringe benefit from employees' income. The law of unintended consequences frequently haunts governmental intervention, and here is a textbook case. Thanks to wartime emergency measures taken 50 years ago, we now have a health insurance system in double crisis, plagued by both explosive overspending and underinclusiveness caused by discriminatory tax rules.

Because of wartime emergency measures 50 years ago, we now have a health insurance system in double crisis, plagued by both explosive overspending and discriminatory underinclusiveness.

What we must do, and what the Patient Power plan proposes, is to end the current discriminatory tax treatment of health care spending and establish tax fairness for all Americans. That goal could be accomplished in one of two ways. Individuals not covered by employer-provided insurance could be granted the same tax deduction that employers are allowed to take. Or, alternatively, employer-provided health insurance could be included in the taxable income of employees, and then all Americans could be granted individual tax credits for health care expenses.

Whatever form the tax incentive takes, it should be structured to allow a direct tradeoff between lower deductible third-party health insurance and self-insurance through depositing money in a Medical Savings Account. For example, the deduction or credit could be tied to the average cost of a low-deductible policy. The higher the deductibles of the policies people chose, the lower their premiums would be, and thus the more money (up to a certain limit, say $3,000 a year) they could deposit in tax-free MSAs. Such an arrangement would allow individuals to choose the mix they preferred of third-party insurance and personal savings.

Cost Savings through Patient Power

The Patient Power plan of Medical Savings Accounts and tax fairness would revolutionize the incentives operating in the health care sector.

oughly two-thirds of all health-insurance-claim dollars in this country fall in the under-$3,000-per-year category. Under the Patient Power plan, people would be spending *their own money* in this dominant sector of the health care market.

Because they could keep what they did not spend, people would have an incentive to spend wisely for health care. A RAND Corporation study found that people enjoying free health care spend about 50 percent more than those who pay 95 percent of their bills out-of-pocket (up to a $1,000 maximum). Furthermore, people with free care are 25 percent more likely to see a doctor and 33 percent more likely to enter a hospital. All that extra spending of other people's money, though, doesn't necessarily buy better results: the RAND study found no apparent differences in most health outcomes for the two groups.

It is important to realize that given the current state of medical

With people spending their own money on health care, doctors, hospitals and other service providers would be forced to compete on price, quality, and convenience to attract patients.

technology, the amounts we could spend on health care are potentially limitless. We could probably spend half our gross national product on diagnostic tests alone. There are currently some 900 different blood tests that can be performed. Why not make all 900 part of an annual checkup? And consider what would happen if every person who chooses to medicate himself with nonprescription drugs decided instead to go to the doctor. To handle the explosion in demand, we would need 25 times the current number of primary care physicians.

Given that the demand for medical services is potentially infinite, health care spending must be limited one way or another. And normally, he who pays the piper gets to call the tune. Thus, under the current system, health care is increasingly rationed by the third-party payers—insurance companies and government bureaucrats. Their control over who ts what—up to and including who lives and who dies—would increase ramatically under managed competition. Patient Power offers the only

viable alternative to bureaucratic rationing: individual choice, with people making their own personal tradeoffs between medical services and other needs.

With people spending their own money on health care, doctors, hospitals, and other service providers would be forced to compete on price, quality, and convenience to attract patients. Currently, such competition is stifled because, by and large, patients are not the real paying customers—government and insurers are. Accordingly, the "prices" on medical bills are not really market prices at all; they are simply a means of passing along costs to third-party payers. And information on quality—for example, mortality rates at hospitals—is not normally made available to patients.

By contrast, competition has been vigorous in those exceptional areas of the health care sector where third-party payment does not dominate. Consider cosmetic surgery, which is not covered by any private or public insurance policy. Patients pay with their own money, and they are treated accordingly. They are generally quoted a fixed price in advance, covering both medical services and hospital charges. They are given choices about the level of service (for example, surgery performed at the doctor's office or, for a higher price, on an outpatient basis at a hospital). For another example, consider America's $12-billion eye care industry, in which costs have been holding steady or even falling in recent years. The simple reason: unregulated price competition.

By eliminating the third-party paper shuffling from small-dollar-amount expenditures, Patient Power would dramatically reduce administrative costs. Such costs today are unusually high (the cost of marketing and administering private health insurance runs between 11 and 12 percent of premiums) because of the enormous number of small claims that unnecessarily clog the present system. The cost of processing many small claims actually exceeds the amount of the claims. By converting to high-deductible policies and letting people pay routine expenses directly out of their Medical Savings Accounts, all that excessive paperwork would be eliminated.

Enormous cost savings could be achieved if the combination of catastrophic insurance and Medical Savings Accounts were extended universally (including replacing Medicare and Medicaid). Total administrative savings are estimated (based on 1990 figures) to be as high as $33 billion a year; in addition, more prudent spending by patients would produce savings of up to an estimated $147 billion a year. After factoring in extra costs of $12

'ion a year due to instituting tax fairness, net total cost savings come to $168 billion—or nearly one-fourth of total annual health care spending in this country. And that rough estimate doesn't even include the savings gained from lower prices that would surely be a major benefit of the new competitive health care marketplace that Patient Power would help bring about.

Conclusion

The Patient Power plan to reform health insurance has three main elements:

1. allow people to make deposits in tax-free Medical Savings Accounts to finance their routine medical expenses;
2. allow people currently receiving employer-provided insurance to fund their Medical Savings Accounts by switching from low-deductible policies to high-deductible catastrophic policies with much lower premiums; and
3. allow all Americans, regardless of whether they receive employer-provided insurance, to claim tax benefits (whether in the form of deductions or credits) for purchasing catastrophic health insurance and making deposits in Medical Savings Accounts.

Notice the key word repeated in all three elements of the Patient Power plan: *allow*. The plan is voluntary: it does not force anyone to do anything. The purpose of Patient Power is to expand people's choices, not narrow them—to enable people to make their own decisions about tradeoffs between health care and other needs, not to create yet another bureaucracy to make those decisions for us.

Only by empowering patients can we tap the power of market incentives to transform our bloated, bureaucratized health care system. So-called reform packages based on further restricting patient choice move in precisely the wrong direction; not only would they be unable to control costs effectively, but they would also imperil the high quality of medical care that Americans currently enjoy. Managed competition is not the answer. Real competition is. The Patient Power plan, by enabling people to spend their own money on medical needs, would inject a whopping dose of real competition into our ailing health care system.

Twenty Questions and Answers about Medical Savings Accounts

1. How would Medical Savings Accounts be administered?

MSAs would be administered by qualified financial institutions in much the same way individual retirement accounts (IRAs) are.

2. How would funds from Medical Savings Accounts be spent?

The simplest method would be by debit card. Patients would use their debit cards to pay for medical services at the time they were rendered. At the end of each month, account holders' statements would show recent expenses and account balances. No more paperwork would be needed than with any other credit card.

3. What would prevent fraud and abuse?

To receive MSA funds, a provider of medical services would have to be qualified under IRS rules. Qualifying should be a simple procedure, involving little more than filing a one-page form. If IRS auditors discovered fraudulent behavior, the provider would lose the right to receive MSA funds and would be subject to criminal penalties.

4. What types of services could be purchased with MSA funds?

Any type of expense considered a medical expense under current IRS rules would qualify. In general, the IRS has been fairly broad in its interpretation of what constitutes a medical expense. An unhealthy step in the wrong direction, however, was the IRS decision to disallow cosmetic surgery. There is no apparent reason why the removal of a disfiguring scar or a change in facial appearance that improves employability and self-esteem is any less important than an orthopedic operation that allows an individual to play a better game of tennis or polo.

5. What tax advantages would be created for Medical Savings Account deposits?

MSA deposits would receive the same tax treatment as health insurance premiums. Thus, under employer-provided health insurance plans, MSA deposits would escape federal income taxes, Social Security taxes, and state and local income taxes. If the opportunity to receive a tax deduction or a tax

edit for the purchase of health insurance were extended to individuals, their deposits to Medical Savings Accounts would receive the same tax treatment. MSA balances would grow tax-free and would never be taxed if the funds were used to pay for medical care or purchase long-term care or insurance to cover long-term care.

6. What about low-income families who cannot afford to make Medical Savings Account deposits?

If low-income families can afford to buy health insurance, they can afford to make MSA deposits, since the primary purpose of the MSA option is to enable individuals to divide their normal health insurance costs into two parts: self-insurance and third-party insurance. Currently, little or no tax advantage is available for people who purchase health insurance on their own. Health insurance would become more affordable for the currently uninsured if they could deduct the premiums from their taxable income. A system of refundable tax credits, which would grant greater tax relief to low-income people, would make insurance even more affordable.

7. How could individuals build up funds in their MSA accounts?

One way would be to choose a higher deductible insurance policy and deposit the premium savings in an MSA. For most people, a year or two of such deposits would exceed the amount of their insurance deductible. An alternative (which tends to be revenue neutral for the federal government) would be to permit people to reduce the amount of their annual, tax-deductible contributions to IRAs, 401(k) plans, and other pensions and deposit the difference in Medical Savings Accounts.

8. What if medical expenses not covered by health insurance exceed the balance in an individual's Medical Savings Account?

One solution would be to establish lines of credit (either with employers or with the financial firms that managed MSAs) so that individuals could effectively borrow to pay medical expenses. Repayment would be made with future MSA deposits or other personal funds. Another solution would be to permit family members to share their MSA funds. This concern would vanish as MSA balances grew over time.

9. How would members of the same family manage their MSA accounts?

Because family members often are covered under the same health insurance policy, it seems desirable to permit couples to own joint MSA accounts and for parents to own family MSA accounts. In those cases, more than one person could spend from a single account. But even if family members maintained separate accounts, that should not preclude the pooling of family resources to pay medical bills.

10. What about people who are already sick and have large medical obligations at the time the plan is started?

Such people might be harmed by a sudden increase in the health insurance deductible unless transitional arrangements were made. Most would benefit from a high deductible in the long run, but they might suffer financially at the outset. One solution is the use of credit lines that can be repaid from future MSA contributions.

11. What about people who have a catastrophic illness with large annual medical bills likely to last indefinitely into the future?

Most of those people would be disadvantaged if they had an annual deductible. A better form of health insurance would be one with a per-condition deductible, which would be paid only once for an extended illness.

12. Are there circumstances under which individuals could withdraw MSA funds for nonmedical expenses before retirement?

A reasonable policy is to apply the same rules that now apply to tax-deferred savings plans (for example, IRAs and 401(k) plans). Thus, withdrawals for nonmedical purposes would be fully taxed and would face an additional 10 percent tax penalty.

13. How do we know people would not forgo needed medical care (including preventive care) in order to conserve their MSA funds?

We don't. The theory behind Medical Savings Accounts is that people should have a store of personal funds with which to purchase medical care. And because the money they spend would be their own, they would have strong incentives to make prudent decisions. Undoubtedly, some of their decisions would be wrong. But many decisions made under the current system are also wrong. Under the new system people would at least have funds

hand with which to pay their share of medical bills. And, since people would have an incentive to protect future account balances to cover future medical costs, some would certainly spend more on preventive health care. Because we cannot spend our entire GNP on health, health care has to be limited in some way. The only alternative to government rationing, with decisions made by a health care bureaucracy, is individual choice, with people making their own tradeoffs between medical services and other needs.

14. Given the increasing complexity of medical science, how could individuals possibly make wise decisions when spending their MSA funds?

One thing people can do is solicit advice from others who have superior knowledge. For example, most large employers and practically all insurance companies have cost-management programs in which teams of experts make judgments about whether, when, and where medical procedures will be performed. Those experienced professionals could play an important role in helping patients make decisions about complicated and expensive procedures. Also, telephone advisory services, which are springing up around the country, could well become an important source of expert information in the coming years. In any event, we should let the experts advise and the patient decide.

15. Given the problems that major employers and insurance companies have in negotiating with hospitals, how could individual patients possibly do better?

The reason large institutions have so much difficulty negotiating with hospitals is that institutions are not patients. And the reason patients who spent their own money would wield effective power is the same reason consumers wield power in every market—they can take their money and go elsewhere. Physicians, hospitals, and other health care providers would have considerable incentive to win their business. Moreover, Medical Savings Accounts would not preclude individuals from using employers as bargaining agents.

16. What would happen to Medical Savings Account balances at retirement?

People should be able to roll over their MSA funds into an IRA or some ,er pension fund. Thus, money not spent on medical care could be used,

after taxes, to purchase other goods and services, including post-retirement health care and insurance coverage for long-term care.

17. What would prevent wealthy individuals from misusing Medical Savings Accounts to shelter large amounts of tax-deferred income?

An individual's total tax-advantaged expense for health insurance plus MSA deposits could not exceed a reasonable amount. One definition of "reasonable" would be an annual MSA deposit that would equal the deductible for a standard catastrophic health insurance policy.

18. What about members of HMOs?

They would have the same opportunities as people covered by conventional, fee-for-service health insurance plans. Note that because many HMOs are now instituting copayments, HMO members would have incentives to acquire Medical Savings Accounts. Their HMO premiums plus their MSA deposits could not exceed a reasonable amount, however.

19. Under employer-provided plans, would employees have a choice of deductibles?

Permitting employees to make individual choices makes sense. Over time, different people would have different accumulations in their MSAs and, quite likely, different preferences about health insurance deductibles. Accordingly, employers would have an incentive to provide a range of benefit plans to suit different employee needs.

20. What would happen to flexible spending accounts now available to some employees?

Medical Savings Accounts would replace FSAs under employee benefits law. Currently, employees who make deposits to FSAs must use the money or lose it, typically within 12 months. Similar deposits made to Medical Savings Accounts would have no such restrictions.

Ten Advantages of Medical Savings Accounts

1. The cost of health insurance would be lower.

MSAs would allow people to substitute less costly self-insurance for more costly third-party insurance for small medical bills. To the degree they were self-insured, people would no longer face premium increases caused by the wasteful consumption decisions of others. And to the extent that third-party insurance was reserved for truly risky, catastrophic events, the cost per dollar of coverage would be much lower than it is today.

2. The administrative costs of health care would be lower.

Because we rely on third parties to pay a large part of almost every medical bill, unnecessary and burdensome paperwork is created for doctors, hospital administrators, and insurers. By one estimate, as much as $33 billion a year in administrative costs could be saved by the general use of Medical Savings Accounts.

3. The cost of health care would be lower.

Medical Savings Accounts would institute the only cost-control program that has ever worked: patients' avoiding waste because they have a financial incentive to do so. When people spent money from their MSAs, they would be spending their own money, not someone else's—an excellent incentive to buy prudently. By one estimate, the general use of Medical Savings Accounts would reduce total health care spending by almost one-fourth.

4. Financial barriers to purchasing health care would be removed.

Under the current system, employers are responding to rising costs of health insurance by increasing employee deductibles and copayments. Market prices are also encouraging people who buy their own health insurance to opt for high deductibles and copayments. One problem with that trend is that people with low incomes who live from paycheck to paycheck may forgo medical care because they cannot pay their share of the bill. Medical Savings Accounts would ensure that funds were available when people needed them.

5. Financial barriers to purchasing health insurance during periods of unemployment would be removed.

Under current law, people who leave an employer who provided their

health insurance are entitled to pay the premiums and extend their coverage for 18 months. Yet, the unemployed are the people least likely to be able to afford those premiums. Medical Savings Accounts would solve that problem by providing funds that were separate from those available for ordinary living expenses. MSA funds might also be used to purchase between-school-and-work policies or between-job policies of the types already marketed.

6. The doctor-patient relationship would be restored.

Medical Savings Accounts would give individuals direct control over their health care dollars, thereby freeing them from the arbitrary, bureaucratic constraints often imposed by third-party insurers. Physicians would view patients rather than third-party payers as the principal buyers of health care services and would be more likely to act as agents for their patients rather than for an institutional bureaucracy.

7. We would enjoy the advantages of a competitive medical marketplace.

Patients who enter hospitals can neither obtain a price in advance nor understand the charges afterward. Those problems have been created by our system of third-party payment and are not natural phenomena of the marketplace. When patients pay with their own money (as is the case for cosmetic surgery in the United States and most routine surgery at private hospitals in Britain), they usually get a package price in advance and can engage in comparison shopping.

8. We would enjoy the advantages of real health insurance.

Because health insurance today is largely prepayment for consumption of medical care, people with preexisting health problems often cannot buy insurance to cover other health risks. Medical Savings Accounts would encourage a market for genuine catastrophic health insurance and would make such insurance available to more people.

9. Incentives for better choices of lifestyle would be created.

Because MSAs would last people's entire lives, they would allow individuals to engage in lifetime planning and act on the knowledge that health and medical expenses are related to their choices about lifestyle. People would bear more of the costs of their bad decisions and reap more of the

fits of their good ones. Those who didn't smoke, ate and drank in moderation, refrained from drug use, and otherwise engaged in safe conduct would realize greater financial rewards for their behavior.

10. Health insurance options during retirement would be expanded.

Most Medical Savings Accounts would eventually become an important source of funds with which to purchase health insurance or make direct payments for medical expenses during retirement. Such funds would help solve the growing problem of long-term care for the elderly.

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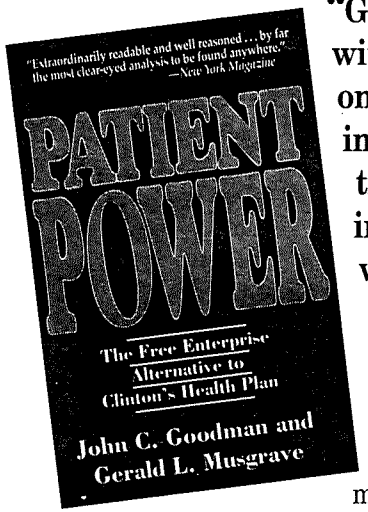
To learn more about Patient Power, read *Patient Power: The Free-Enterprise Alternative to Clinton's Health Plan.*



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PATIENT POWER

The Free-Enterprise Alternative to the Clinton Health Plan

Statement to The Kansas House Public Health and Welfare Committee
March 23, 1994

Will Hendricks
5736 West 81st Terrace
Prairie Village, Kansas 66208
Phone (913) 649-2888

Honorable Committee Members:

I thank the Committee for the opportunity to speak today. About myself, - I have been actively working for health care reform since the fall of 1990. I am the author of a Kansas Citizen's Health Care Plan. Submitted to the Joint Committee on Health Care for the 90s, the plan was well received and was forwarded to the 403 Commission for their consideration. I speak only as a citizen of Kansas. I have no other ax to grind, I have absolutely no connection to the health care industry, and I have no stake personally in health care reform since my wife and I have adequate insurance coverage. I do however worry about my children. And I believe that the costs of health care to consumers should be fair and that their security should not be lost if they experience an illness. Finally, I believe that quantity and quality of care provided to Kansas citizens should take priority over cutting cost for the sake of cost cutting. Universal access and comprehensive coverage are the absolute minimum requirements for Kansas citizens now and in the future; they are not negotiable.

I strongly support HB3075. Termination of the 403 Commission leaves a vacuum in our ability to protect Kansas from poorly thought out national legislation. The proposed independent Kansas Health Council can not only offer protection against the arbitrary State mandates coming out of Washington, they can find rational, humane and cost effective solutions to our own health care problems. We here in Kansas have a choice. We can continue the present chaos, we can support the Clinton plan with all of its considerable flaws, or we can enact HB3075 and get a start on developing a Kansas Plan for Kansans. The Health Council can follow up on the many good ideas of the 403 Commission. There is much work to be done in developing the goals and details of a Plan. We should all participate in this effort by offering our ideas and expressing our concerns to the new Health Council. Only in this way can we keep our health care dollars at home and have a Kansas Plan for Kansans. This is not a partisan issue. Please do great service to the citizens of Kansas and vote for Kansas House Bill No. 3075. Tell our U.S. congressmen and senators that Kansans want to specify how their health care will be delivered.

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I have talked to many people since I began working on health care over three years ago, and I found only one young store clerk not interested in health care reform. People really do care. You can't speak out if you have no channel and if you are confused and depressed by a situation you believe you can do nothing about. Their confusion is understandable. We are being buried in misinformation. The major players in national level health care are spending tens of millions of dollars to confuse and misinform both the public and legislators. As anyone can observe, the media present the views of these major players almost exclusively. Here are some examples of misinformation:

* They say their plans will save money. They will not. Under the major player plans their profits will be unlimited.

* They say their plans will improve the quality of care. They will not. The plans most favored in Washington say very little about care.

* They say we will be able to choose our own doctor. Not under the major player plans, except at great expense if at all.

* We want to be free of worry about major illness bankruptcy. Their plans do not solve the problem, although they claim they do.

* They say that proper reform will cost untold billions in new taxes. It will not if we can end up with an honest plan. The 403 Commission's analysis in their Kansas Specific Plan has demonstrated the feasibility of providing health care for all citizens without an increase in costs.

* Most of the plans that can really extend health care to the uninsured and improve health care for the rest of us are single payer plans. There is probably more distortions of fact about single payer plans than on any other subject. Opponents of health care reform never miss a chance to misinform the public. The media never bring up the subject in a positive way, and proponents are practically never allowed to speak. We will not succeed in cutting health care costs without some form of single payer plan. In HB30775, the "single buyer" idea is at least moving in the right direction.

* They say that the huge for profit provider corporations are best able to manage health care efficiently. Another falsehood. The corporations have an overhead cost of over ten percent as opposed to Medicare with under five percent.

* They say that it is necessary for small businesses to pay a payroll tax and manage their employee's health care insurance. This is the worst of the options and a disaster for small business.

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Attm. #7-2

* They say it is necessary that Doctors have insurance companies looking over their shoulders. This is a sure way to lower the quality of care. It is amazing how many physicians still oppose single payer plans which would not disrupt their practice. They should become better informed.

* They say that the high cost of malpractice insurance is the fault of the victims. This is demonstrably false. Few patients sue, fewer collect large compensation.

* They say it is necessary to force patients into HMOs. Again, not so. There are many good HMOs, but many restrict care and access to Doctors. And fee for service care can be competitive without reducing compensation for physicians and others delivering care. Simply restrain the bad actors.

* They say it is necessary for Doctors to function as "gatekeepers" to hold down the costs instead of providing care. This idea is an atrocity.

* They say that use of high technology in medicine is causing costs to rise. The opposite is true. A single MRI scan can save tens of thousands of dollars by catching problems early, not mentioning the saving in pain and suffering. The Health Care Purchasing Cooperative of HB3075 will provide the negotiating strength to keep costs down.

* Finally, they say they will provide for universal access and comprehensive care on a timely basis. The plans of the major corporate providers will not do so.

Both the 403 Commission's Kansas Specific Plan and the Kansas Citizen's Plan offer better solutions to most problems, and these plans are designed for the benefit of Kansas citizens, not for out of State supercorporations.

The S&L scandal would pale into insignificance if the public understood the implications of most of the plans being considered in Washington. These plans would essentially transfer control of the Nation's 1.7 trillion dollar per year health care industry to a relatively few large for profit corporations, and there would be no restrictions on the profits they could generate. Their control would have the effect of a single giant monopoly with all of the cost inflation potential that implies. We cannot stand quietly without a fight and allow our health care dollars to flow out to these huge eastern corporations. The more that Kansas health care dollars move out of the State, the less money will remain for our own health care needs. Kansas needs people who will work full time for our State interests. We need to know when legislation damaging to us is being considered or is up for a vote in Washington. We need people who will stand up for our citizens, and will fight for the health care future of Kansas. HB3075 will form the Kansas Health Council to provide for these needs.

Will Hendricks

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

House Public Health and Welfare Committee
Testimony on House Bill 3075
Regarding the Kansas Health Council and the
Kansas Health Care Purchasing Cooperative

March 23, 1994

****

The 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 and members of the committee, thank you for this opportunity to testify on House Bill 3075. This bill creates a Kansas health council and a Kansas health care purchasing cooperative.

The Department of Social and Rehabilitation Services is in favor of the creation of a council where efforts for health care reform are centralized and compliance with federal requirements are assured. We would recommend the Kansas health council include representation from SRS as the single state agency for Medicaid policy and regulations. Kansas Medicaid serves 195,000 Kansans monthly.

Many benefits and advantages for SRS could be realized with the purchasing cooperative negotiating contracts for Medicaid health care services. As the bill abolishes the health care commission, we could enter into an interagency agreement with the purchasing cooperative to negotiate contracts for the Medicaid population. This would eliminate duplicate administrative efforts and maintain single state agency authority with SRS.

The Medicaid program is a highly efficient operation with 4 percent of the total costs attributed to administration. The health council and purchasing cooperative would need to assure that both administrative and service costs continue to be efficient and reasonable.

SRS could support this bill, with the following concerns addressed:

- To maintain federal funding, SRS as the single state agency will need to maintain responsibility and authority for Medicaid policy, regulations and state plan.
- Adequate and appropriate timelines need to be established for the appointment of the Kansas Council, purchasing cooperative and advisory committees.
- It is important that any advisory and/or consumer committees include consumers of Medicaid service programs, due to their special service needs.

In summary, SRS supports this bill as we seek to provide access to quality health care for our clients through health care reform. SRS wants tocontinue with Senate Bill 119 implementation as part of the managed care statewide.

Donna L. Whiteman
Secretary

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SRS Medicaid Managed Care — Fact Sheet #2

Managed Care Timeline and Work Plan

Topic	Date	Status
Hire key staff	**October, 1993**	**Done**
Establish State task force	**January, 1994**	**Done**
Prepare decision papers	**January, 1994**	**Done**
Establish community/local workgroups	**March, 1994**	**Done**
Compilation of actuarial data	**March, 1994**	**Done**
Determine program goals and objectives	**March, 1994**	**Done**
Determine proposed managed care process	**March, 1994**	**Done**
Create work plan	**March, 1994**	**Done**
Determine program structure	March, 1994	In progress
➤ Determine managed care market		In progress
➤ Determine viability of Physicians Care Network		In progress
➤ Determine Federal/State HMO laws		In progress
Determine program enrollment procedure		In progress
Determine basic benefit package and services	April, 1994	
➤ Evaluate current Medicaid services		
➤ Evaluate available managed care services		
Begin developing provider network		
Determine role of local health departments, FQHCs, CHCs, and LEAs	May, 1994	
Develop Quality Assurance Plan		
Develop general information systems req. for information systems reprocurement		
Determine if the recipient enrollment will be guaranteed	June, 1994	
Begin Waiver development		
Set rates and stop-loss insurance	July, 1994	
Determine how services will be tracked		
Begin RFP preparation		
Determine open enrollment issues	August, 1994	

Since the adoption of K.S.A. 39-7, 111, SRS has begun to develop the managed care program and project outlined by the 1993 Legislature. At this time, implementation is expected to begin 7/1/95.

For more information about the SRS Managed Care program, contact:

Robert Epps, SRS Commissioner of Income Support and Medical Services, (913) 296-6750

Brenda Eisele Jackson, SRS Director of Managed Care (913) 296-3981

Over

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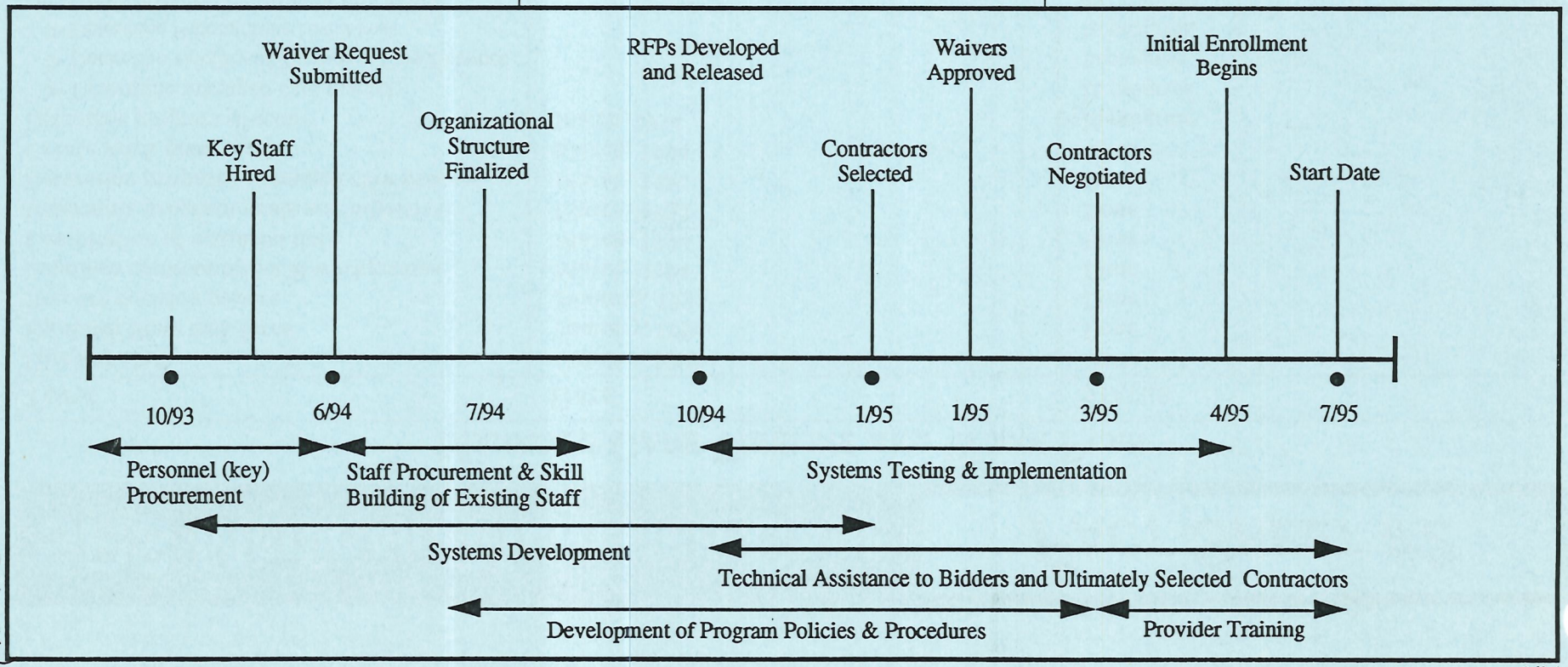
SRS Medicaid Managed Care
Fact Sheet #2

Topic	Date	Status
Develop information systems (MMIS) and data collection requirements	September, 1994	
➤ Develop modifications to MMIS		
➤ Develop detailed MMIS requirements		
RFP is released	October, 1994	
Begin finalizing contract	January, 1995	
Plan training materials and programs		
Begin training providers and choice workers	February, 1995	
Finalize contracts	March, 1995	
Begin enrollment	April, 1995	
Begin program	**July, 1995**	



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LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

835 SW Topeka Blvd. Topeka, Kansas 66612-1671 (913) 357-6321 FAX (913) 357-4732

HB 3075

March 23, 1994

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Public Health and Welfare

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Madam Chairperson and members of the Committee:

My name is Terry Leatherman. I am the Executive Director of the Kansas Industrial Council, a division of the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to explain why KCCI reluctantly opposes passage of HB 3075 at this time.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

KCCI feels the heart of HB 3075 is the creation of the Kansas Health Care Purchasing Cooperative. The Cooperative has a laudable goal of increasing insurance availability to employers

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Attm # 9

or less than 100 employees, the employer group most likely to not provide an insurance program for their employees. However, HB 3075 attempts to deliver on its promise by creating a government-run insurance entity. There are several reasons why KCCI is hesitant to endorse such a plan.

1. In January, KCCI surveyed its members regarding six major Congressional proposals to reform the nation's health care system. The KCCI report and a summary sheet of preliminary survey results are enclosed for your review. On one survey question, KCCI members were asked how they would prefer to see health care insurance changed.

Three of the federal proposals contain, in varying degrees, purchasing cooperatives. They are President Bill Clinton's proposal, which calls for mandatory employer participation in "alliances," and plans from Senator John Chafee and Representative Jim Cooper, which would create voluntary purchasing cooperatives.

KCCI member support for President Clinton's alliance structure was 6%. The Chafee and Cooper plans had greater support at 20% and 18%, respectively. However, all three of those proposals trailed insurance reforms by Representative Bob Michel (21%) and Senator Phil Gramm (29%).

The center of the Michel/Gramm insurance reforms is to improve today's market through novel concepts (such as Medical Savings Accounts), greater consumer participation, private purchasing cooperatives, elimination of preexisting condition restrictions, and portability of insurance from job to job.

2. The Cooperative proposed in HB 3075 is structurally designed to become a "Regional Alliance" if President Clinton's health care reform becomes law. While the political winds in Washington shift quickly, it does appear unlikely today that the President's vision of reform in this area will be the one that prevails when Congressional action concludes.

3. Privatization has been a much supported concept in the Kansas Legislature in 1994. KCCI has staunchly supported this movement. It is structurally evident that the private sector can efficiently and effectively carry out many current government services and thereby lower the bureaucracy of government.

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~~Pg 2 of 9~~

However, in the biggest social issue in our country and state today, HB 3075 proposes reverse this trend. The proposed Cooperative would be a government insurance agency competing with private insurance programs, at the least, or could possibly be the health care insurer of all Kansans in the future. This is totally counter to today's prevailing attitude that government should have less of a role in the life of its citizens.

Thank you for the opportunity to explain why KCCI is concerned about passage of HB 3075. I would be happy to answer any questions.

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attm #9-3
~~pg 3 of 9~~

HEALTH CARE

Kansas Chamber of Commerce and Industry

835 SW Topeka Blvd. Topeka, Kansas 66612-1671 (913) 357-6321 FAX (913) 357-4732

January 1994 Health Care Report #2

KCCI Compares Major Health Care Plans

Who Has The Best Health Care Reform Plan? Maybe You Do.

Please share your views on health care reform by completing and returning the appropriate form in accordance with the instructions below. KCCI must have this information to adequately represent you. Please reply by January 31.

KCCI's Health Care Report #2 reviews the key issues in the six major health insurance reform proposals which will be considered by the United States Congress in 1994.You will see the contrast in these six reform proposals inside this report. In addition, a seventh column is included for YOUR views on how health care should be reformed. Review the bill comparisons and in the final column to select which plan you feel Congress should pursue. For example, criteria 'A' concerns the overall objectives of the plans. If you feel the Cooper Plan (3) is the best in this category, you would put '3' in the final 'A' column. After completing the final column, please detach that portion of the report and return it to KCCI.

KCCI plans to compile the responses from our members and share the information with our elected officials in Washington and Topeka. In order to assure this report truly reflects the feelings of the Kansas business community, make sure you complete and return your views to KCCI. You are also encouraged to include this report in your notebook of KCCI reports on health care.

After reviewing the inside pages of this report, please note that a "health care glossary" of terms being used by health care reformers is included on the back page. Our next report will review health care reform proposals which will be considered by the Kansas Legislature in 1994.

The six proposals are:

❶ **THE CLINTON PLAN** - The American Health Security Act, which was developed by First Lady Hillary Rodham Clinton's Health Care Reform Task Force and is being proposed by the Clinton Administration.

❷ **THE CHAFEE/DOLE PLAN** - The Republican Senate Alternative for health care reform. The principal author of the plan is Rhode Island Senator John Chafee.

❸ **THE COOPER PLAN** - The author of the bill is Representative Jim Cooper, a Tennessee Democrat. This bill touts bi-partisan support.

❹ **THE McDERMOTT PLAN** - The bill's author is Representative Jim McDermott, a Washington Democrat, and has 89 co-sponsors in the House. Similar legislation is proposed in the Senate. The bill calls for a government operated health care system.

❺ **THE GRAMM PLAN** - The bill's author is Texas Republican Senator Phil Gramm. The major reform concept in this bill is promotion of Medical "IRAs."

❻ **THE MICHEL PLAN** - The Republican House Alternative for health care reform. The principal sponsor is House Minority Leader, Illinois Representative Bob Michel.

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CRITERIA	❶ Clinton Administration Plan	❷ Chafee/Dole Senate GOP Alternative Plan	❸ Cooper A Bi-partisan House Plan
A. WHAT IS THE OBJECTIVE OF THE HEALTH REFORM PLAN?	All Americans will have health insurance coverage by 1998. This is accomplished by mandating employers to provide health insurance to employees.	All Americans will have health insurance coverage by 2000. This is accomplished by requiring individuals to purchase health insurance.	Voluntarily expand the availability of health insurance through "managed competition."
B. HOW WILL HEALTH CARE INSURANCE BE CHANGED BY THE PLAN?	Health Alliances would be the link between citizens and health care providers. Employers would be required to purchase health plans through the Alliance. Employers of more than 5,000 could establish their own "Corporate Alliance." Insurance companies, HMOs and managed care groups would need an Alliance's approval to operate. Approval would require health plans to use "community rating," and not exclude people for health reasons.	Private Sector Purchasing Cooperatives would be formed for employers of less than 100. The Cooperatives would be owned by member businesses and would be formed in all states. Purchasing Cooperatives and Qualified Health Insurance Plans would use "community rating" and could not exclude people for health reasons.	Each state would form at least one Health Plan Purchasing Cooperative (HPPC). The HPPC would offer each enrollee a menu of accountable health plans (AHP), which are developed by insurance companies and health care providers. Each enrollee, not their employer, will choose their preferred AHP and may change plans annually. HPPCs will collect individual and employer-based premiums and pay AHPs. A 1% premium tax will pay for HPPC administration costs.
C. WHAT RESPONSIBILITIES DO EMPLOYERS HAVE IN THE REFORM PLAN?	Employers must pay a minimum of 80% of a full time employee's premium and a pro-rated percentage of a part time employee's premium. The employers premium participation is capped as low as 3.5% of payroll, or as much as 7.9% of payroll. The cap level is based on the business' number of employees and their wages.	Employers must offer their employees health insurance coverage, but are not mandated to pay a percentage of their premium. To assist individuals purchase insurance, there is a phased-in subsidy, which starts at 90% of poverty and increases to 240% of poverty by the year 2000.	Employers are not mandated to pay a percentage of their employee's health insurance premium. However, employers of less than 100 must join HPPCs. States would be given the flexibility to increase the employee threshold number, so long as no more than half of a state's employees are insured by the HPPC.
D. WHERE WILL THE DOLLARS FOR HEALTH CARE BE GENERATED?	Most health care dollars will come from employer/employee health care premiums. Insurance plans will also have co-payments and deductibles. "Corporate Alliances" will pay a 1% payroll tax. There will also be a tax increase on tobacco products.	Most health care dollars will come from insurance premiums, co-payments and deductibles. There will be a "tax cap" on how much insurance premium cost can be deducted from taxes.	Most health care dollars will come from insurance premiums, co-payments and deductibles. There would be a cap on tax deductibility of employer premium contributions.
E. WHAT HEALTH CARE COST CONTAINMENT FEATURES ARE CONTAINED IN THE PLAN?	There will be an overall limit on health care expenditures by placing "global budgets" on Health Alliances. Savings will be realized by streamlining claims administration process.	The plan proposes medical malpractice reforms, uniform claims processing, and antitrust reform to allow the sharing of resources.	The plan proposes medical malpractice reforms, uniform claims processing, a phase out of Medicare subsidy for upper-income beneficiaries and reduced growth in Medicare provider fee increases.

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4 McDermott "Canadian Model" Plan	5 Gramm By Sen. Phil Gramm (R-Texas)	6 Michel House GOP Alt."Incremental Reform"	KCCI Member Plan List the plan number in the boxes below to design your plan. Select one number only.
All Americans will have health care coverage by 1996. This will be accomplished by government becoming a "single payer" of health care.	Voluntarily expand the availability of insurance through insurance reform and "medical savings accounts."	Voluntarily expand the availability of insurance through insurance market reforms.	A.
All Americans would be insured through the government program. Private insurance could only insure health needs that are outside the benefit package provided by the government program.	Current private insurance process would not be changed. The plan does produce a new insurance concept, the Medical Savings Account. Voluntary employer/ employee contributions would purchase a $3,000 deductible catastrophic insurance policy and fund a Medical Savings Account. Tax free withdrawals from the Account to pay out-of-pocket medical expenses which apply to deductible. Other Account withdrawals would be considered "income."	Insurers who sell small group health plans would be required to offer a Standard Health Plan, a Catastrophic Plan and a Medisave Plan to all businesses who employ two to 50 employees. Pre-existing condition restrictions would be limited, as would allowable premium increases. Group purchasing arrangements would also be encouraged by eliminating current IRS regulatory burdens.	B.
Employers would have no role in the plan, except for paying taxes to pay for the health care program.	Employers would not be required to pay a percentage of an employee's insurance premium, but would be required to offer employees three health insurance alternatives. They are: 1) a standard health insurance plan, 2) an HMO-styled health care plan, and 3) a tax free Medical Savings Account.	Employers would be required to offer a health insurance program to their employees, but would not be mandated to pay a percentage of the employee's premium.	C.
A series of taxes would pay for the plan: • a 7.9% payroll tax on all employers • a corporate income tax increase to 38% for businesses with more than $75,000 profit • income tax increases to 15/30/34%-38% income tax for families with more than $200,000 annual income • Medicare payroll tax hike to 6.45% • 85% of Social Security benefits would be considered income	The program is voluntary, placing all financial responsibility on individuals.	The program is voluntary, placing all financial responsibility on individuals.	D.
Spending will be controlled by a national board which will establish a "global budget. " Future budget increases will be limited to growth of the Gross National Product.	The plan proposes to remove antitrust barriers to cooperative efforts, medical malpractice reform, and greater price competition through expanded consumer choice.	The plan proposes to strengthen fraud penalties in health care services, remove antitrust barriers to forming joint ventures, standardized claims processing, and medical malpractice reform.	E. *Fill out reverse side and clip and return to KCCI*

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attm #9-6 pg 6 of 9

Name _____ Company _____

Address _____ City/State/Zip _____

Phone/FAX _____

Circle one of the following: Manufacturing Retail/Wholesale Service Finance Other

Number of employees: 25 or less 25-100 101-499 500 or more

Return to: KCCI, 835 SW Topeka Blvd., Topeka, KS 66612 (913) 357-6321 - FAX (913) 357-4732

GLOSSARY ON HEALTH CARE REFORM

Administrative Streamlining - In order to reduce administrative costs, streamlining would simplify and decrease the amount of paperwork associated with paying providers and delivering care. Reform would include standardization of processes and the introduction of improved information management technologies.

Corporate Alliances - Same as "regional alliances," except operated by employers of more than 5,000 employees, rather than state government.

Employer Mandate - Requirement that all employers offer and pay for a portion of their workers' health insurance coverage.

Global Budget - The number of dollars which would be available to pay all health care costs.

Individual Mandate - Requirement that individuals assume responsibility for securing their own health insurance.

Insurance Market Reform - Changing the practices of insurance companies in selling health insurance to small businesses and individuals. The purpose is to eliminate competition among health insurance companies based on the selection of low risk customers. Reforms often include eliminating insurance companies' ability to deny health insurance or charge higher premiums on pre-existing conditions, require insurers to accept all who wish to enroll for coverage and guarantee their ability to renew coverage, and providing consumer information.

Managed Competition - A concept which calls for government action to cause "free market" competition. The goal of managed competition is cost containment by causing the health care market to lower costs in order to attract business.

Medical Savings Account - A special "IRA" in which individuals would deposit money for future out-of-pocket health care expenses. They would make contributions to the account on a pre-tax basis, up to specific amounts.

Purchasing Cooperatives - State established programs which band small businesses and individuals together into groups for the purpose of gaining a better ability to spread risk and gaining greater market leverage when purchasing health insurance.

Regional Alliances - Like "purchasing cooperatives," alliances are state established programs where businesses purchase health insurance. By banding employees together, alliances are able to spread risk and gain purchasing leverage. Alliances will collect health premiums, work within global budgets, and approve all health plans.

Tax Cap - For employers, the tax cap is the benefit level at which they can no longer deduct as a business expense the cost of health insurance in determining taxable income. No deduction can be taken on the portion or value of benefits that exceeds the specified level. For individuals, the tax cap is the benefit level beyond which any amounts would be treated as income to the employee. Beyond the specified level, individuals would be subject to income and payroll taxes, and employers would be liable for their share of payroll taxes.

Universal Coverage - Enrollment of all Americans in health insurance.

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KCCI Members Respond to Health Care Query

When given a chance to choose between the major health care legislation in Washington, the Kansas business community is not choosing the Clinton Administration's prescription for health care reform. Instead, Kansas business men and women appear to support more of the provisions in the proposals of Senator Phil Gramm and Senator John Chafee. This conclusion is the preliminary result of a survey conducted by the Kansas Chamber of Commerce and Industry (KCCI). The survey was sent the 3,000 members of KCCI.

"The lack of support for the Clinton Health Security Act and the McDermott "Canadian Plan" shows that KCCI members do not feel that new government bureaucracies are the answer to the problems in our country's health care system," said Ed Bruske, KCCI president. In fact, Bruske indicated that many in the Kansas business community are not convinced there is a crisis. "The word 'crisis' is too much and doesn't describe the situation," said Bruske. "KCCI members apparently feel that the health care system needs reform and improvement, but certainly doesn't merit trashing or complete overhaul," Bruske said. "Instead, they are saying we need to find ways to stimulate the private sector to develop innovative approaches to make health insurance more available and affordable. Affordability is the key word."

The KCCI survey compared six major health care proposals before Congress in five key areas. They were: the plan's objectives; how the plans would alter the health insurance market; what role employers would play in the plan; how will health care reform be financed; and cost containment features. Preliminary survey results are reviewed below.

A copy of KCCI's Health Care Survey, which was mailed to KCCI members in January, is included.

If you have not completed the survey, please do so now.

For more information, call:
Terry Leatherman, KCCI: 913/357-6321

Preliminary survey results are shown on the reverse side — please use Health Care Report #2 for information about each specific plan.

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3-23-94
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~~pg 8 of 9~~

CRITERIA	❶ Clinton Administration Plan	❷ Chafee/Dole Senate GOP Alternative Plan	❸ Cooper Bi-partisan House Plan	❹ McDermott "Canadian Model" Plan	❺ Gramm By Sen. Phil Gramm (R-Texas)	❻ Michel House GOP Alt. "Incremental Reform"	KCCI Memb Preference The plan(s) designated in this column received majority support in preliminary survey results
A WHAT IS THE OBJECTIVE OF THE HEALTH REFORM PLAN?	9%	25%	13%	5%	31%	16%	Gramm Chafee
	▪ *Three of the plans (Clinton, Chafee and McDermott) have an objective of health care coverage for all Americans. The other three plans (Cooper, Gramm and Michel) propose voluntary expansion of health care insurance. When survey responses are combined, 60% of KCCI members supported voluntary expansion plans, while 40% supported proposals calling for universal coverage.*						
B HOW WILL HEALTH CARE INSURANCE BE CHANGED BY THE PLAN?	6%	20%	18%	6%	29%	21%	Gramm Michel
	▪ *President Clinton's proposal to create "regional alliances" where health insurance would be purchased had only 6% survey support.* ▪ *The Gramm and Michel plans promote the "medical savings account" concept. When combined 50% of survey respondents supported the Gramm and Michel plans.*						
C WHAT RESPONSIBILITIES DO EMPLOYERS HAVE IN THE REFORM PLAN?	9%	18%	9%	5%	35%	24%	Gramm Michel
	▪ *There was strong survey support for the Gramm plan, which requires employers to offer, but does not mandate participation in the purchase of three health insurance options for employees.* ▪ *The Chafee and Cooper plans, which both call for small employers to join health insurance purchasing cooperatives, had less support in this question than the others.*						
D WHERE WILL THE DOLLARS FOR HEALTH CARE BE GENERATED?	11%	26%	16%	5%	26%	16%	Chafee Gramm
	▪ *The Gramm/Michel plans, which have no government costs associates with their programs, had a combined survey support of 42%. The Chafee/Cooper plans, which included reform on tax deductibility of health insurance, had 42% support.*						
E WHAT HEALTH CARE COST CONTAINMENT FEATURES ARE CONTAINED IN THE PLAN?	5%	17%	18%	6%	18%	36%	Michel
	▪ *The Clinton/McDermott plans, which both promote "global budgets" for health care costs, had combined support of only 11%.* ▪ *The Michel plan, which emphasized strengthened fraud penalties, was the most supported plan by a wide margin in this category. The Michel plan received significantly more support in this category than in any other.*						

Attm #29

KANSAS COMMISSION ON DISABILITY CONCERNS
1430 SW Topeka Blvd
Topeka, KS 66612-1877
(913)296-1722 (V) 296-5044 (TTY) 296-1984 (Fax)

TESTIMONY PRESENTED TO HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

by

Sharon Joseph, Chairperson
March 23, 1994

House Bill 3075

Madam Chair, members of the committee, thank you for this opportunity to testify in support of House Bill 3075.

Kansas Commission on Disability Concerns (KCDC) advocates for the rights of people with disabilities and promotes policies that are favorable for the independence of people with disabilities.

KCDC supports HB 3075 as the best option that has been proposed thus far this session. We feel very strongly that something must be done in Kansas to ensure that health care reform measures adopted by Congress are implemented in a way that fits the needs of Kansans. A few of the items in this bill that we support specifically are:

- New Sec. 5 (c) that mandates the council work cooperatively with relevant consumer groups in the development of an integrated health plan for all Kansans.

- New Sec. 5 (d) that requires formal public participation prior to the final adoption of a state health care benefit package.

- New Sec. 10(b)(1) that requires the advisory committees under the Kansas Health Care Purchasing Cooperative be made up of one-half consumers and one-half providers.

It does not appear that this bill does anything to address the issue of universal coverage, nor does it address the specific needs of people with disabilities. In order to address these issues we would like to propose that the Kansas Health Council be expanded to five members and that at least one of those members be representative of people with disabilities.

Thank you for allowing me to testify today. I would be glad to attempt to answer any questions you might have at this time.

PH/W
3-23-94
Attm # 10

MELVILLE W. GRAY, P.E.
Route One - Box 483
Perry, KS. 66073
(913)597-5671

TESTIMONY ON HB 3075
By
Melville W. Gray
23 March 1994

I am Mel Gray and I am a retirant under the KPER System. Because I am an old man, I have considerable concern, and indeed much at stake, over the future of health care in Kansas and our nation.

First, let me point out a few of many truisms about "old people" and health care.

1. This is an excerpt from a newspaper article relative to health care, written by a professor of philosophy at one of our great universities.

   "Some have proposed an 'age criterion.' After a certain age, society will withdraw public support of medical cost and let patients fend for themselves." "The cut-off age must be to some extent arbitrary. Suppose it's 72. Those a week shy of 72 will receive care, those a week older won't. That's difficult to justify. <u>This policy would reinforce society's already low opinion of the eldery.</u>"

2. The following is from an AP article by Paul Raeburn entitled "UNDERUSE OF HEART DRUGS CITED".

   "Many doctors are not prescribing the right drugs for congestive heart failure, which afflicts 3 million Americans and costs $60 billion a year to treat."
   "Family doctors are less likely than cardiologists to use the drugs, raising questions about health reforms in which general practioners are expected to be 'gate keepers', said Dr. Michael Bristow of the University of Colorado School of Medicine in Denver".
   "In a study to be published this spring (1994), Bristow found that only 24 percent to 30 percent of patients with heart failure were getting the drugs that have proved to be the best remedy."
   "Dr. William Coleman, president of the American Academy of Family Physicians, disagreed with Bristow. He said family doctors are qualified to treat it."
   "When somebody's a specialist, they want to make something more complex than it is,' said Coleman."
   "Coleman said he believes many patients with mild or moderate heart failure don't need the drugs. Bristow said cardiologists are absolutely certain that the drugs are helpful even in mild cases."

PH+W
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attm #11

The first truism is directly related to the provisions of HB 3075. There is proposed a new agency, the Health Council that will have the responsibility of developing a comprehensive health care plan for all Kansans which must be ready for implementation by July 1998. There is also established the Health Care Cooperative which also has the responsibility of developing a comprehensive health care plan and no state agency may purchase health care insurance, but must allow the Cooperative to do so. This plan must be ready for implementation by July 1997.

Besides duplication of effort and out of phase implementation, the Cooperative is specifically prohibited from including consideration of medicare patients.

These features of HB 3075 will "make homeless", for health insurance purposes, well over ten-thousand state retirants and spouses who are dependent on piggy-backing on supplemental coverage under state auspices.

The second truism is also directly related to the conditions of HB 3075. For a good many years, the government and the medical providers have been professing "it's your body, take charge of it". I for one am prepared to take charge. I am prepared to make the decisions as to what course treatment should take (armed with statiscal data from competent physicians). To do so, I must have the freedom of choice of doctors, whether they are within a HMO, alliance, or other artificial boundary, or whether they are located out of state. I have personal knowledge, & know of other instances, where SELF REFERRAL is the flexible essential making the difference between cure, near-cure, crippling, and even death. It is easy to make a bureaucratic decision in these matters when it is not YOUR LIFE in question.

I am not yet ready to trust these old bones to the "wisdom" of a nameless and faceless bureaucrat, who may still be wet behind the ears, regarding the WHAT, WHERE, & WHEN of my family medical treatment.

The passage of comprehensive health care legislation is a staggering task and should not be undertaken lightly. A plan for young people is a severe responsibility, where the plan dictates care and treatment for "old people" it is virtually impossible when developed by a YOUNG, HEALTHY, bureaucrat.

Whatever the Kansas Legislature initially undertakes regarding health care legislation, could very well establish precedent and influence Kansas health care for years to come. This action should not be in haste without careful deliberation.

I trust the committee will take my remarks in the light in which they are intended - to make a point. I also hope that you will not pass HB 3075 in it's present form.

PH+W
3-23-94
Attm #11-2
pg 2 of 2

Kansas AFL-CIO

110 W. 6th St. Topeka, KS 66603 (913)357-0396

House Committee on Public Health and Welfare
Representative Joann Flower, Chairperson
Wednesday, March 23, 1994, 1:00 p.m.
Room 423 S

Madame Chairperson & Committee Members:

I'm Jim DeHoff, Executive Secretary of the Kansas AFL-CIO. I appear before you today to encourage passage of HB 3075 that would establish the Kansas Health Care Council and the Kansas Health Care Purchasing Cooperative.

I would ask that you amend HB 3075, Section 9A, line 15, item number 4 and add a Kansas AFL-CIO representative and possibly a Kansas Chamber of Commerce and Industry representative. We feel this request is very justified because of the involvement of the AFL-CIO's 95,000 members with health and welfare programs that are in place because of negotiated contracts. Many of our members serve as joint trustees with management. Our membership has the expertise and experience to be a very active participant with the Kansas Health Care Purchasing Cooperative.

We encourage you to amend HB 3075 and urge you to pass HB 3075 favorably.

Thank you.

Jim DeHoff
Executive Secretary

P&W
3-23-94
Attm #12

Testimony on HB 3075
Before the House Public Health and Welfare Committee
By: Larry W. Magill, Jr., Executive Vice President
Kansas Association of Insurance Agents
March 23, 1994

Thank you Madam Chairman, and members of the committee for the opportunity to appear today in opposition to HB 3075. Our association is opposed to a single payer health care plan and to a single state health insurance purchasing cooperative (HIPC) or alliance. Clearly this measure is intended to take Kansas down the road toward a single payer plan.

We support a joint legislative committee as proposed under SB 816 to develop further reforms to Kansas' health care delivery system. We think that the joint committee created under SB 816 would be representative of the make-up of the legislature with a better prospect of developing a plan that will be enacted.

We do not believe another commission is a wise use of state resources at a cost of over $1 million. The duties spelled out in the proposal are overly broad and vague and constitute in our view an extensive delegation of legislative authority to this commission.

We support multiple alliances but not the Clinton administration's approach of an exclusive single state HIPC. Alliances are not a new idea. Multiple employer trusts that pooled the buying power of large numbers of small employers have been around for years. But if the concept can be refined and businesses can be brought into more of a control and ownership role in alliances, we are in favor of that.

We are opposed to the state entering the private health insurance

PH+W
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attm #13

business. This is clearly the intent of this legislation where it allows the state group health plan to be converted to an alliance and marketed to businesses of from 3-100 employees. We believe this would make approximately 90% of the businesses in the state eligible for the program.

Without taking a large amount of the committee's time, we are concerned about a number of provisions in the bill and their implications. For example, in new Section 13, what is the definition of managed care? Is it health maintenance organizations? How can you have capitation of services without universal mandatory health insurance coverage? What happens when the money runs out? New Section 13 says the single state alliance may but does not have to allow for fee for services and individual providers. We think the public has clearly shown they want and are willing to pay for the option of purchasing their health care from the provider of their choice.

Why do we need more data collection in both Sections 4 and new Section 15 when the legislature is already implementing comprehensive data collection under other legislation?

We are opposed to creating new, untested entities in the form of health service networks which appear to be either MEWA's (multiple employer welfare arrangements or group self-insurance) or IPA's (independent practice associations that are also self insured). We are not opposed to the concept of self-insurance. In fact, our members have helped a large number of businesses self-insure their <u>individual</u> group health needs over the years. However, group self-insurance is essentially forming assessable mutual insurance companies outside the

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pg. 2 of 4

laws and regulations of the Insurance Department and its oversight and control.

Our association is opposed to the health service networks created under new Section 16. Again, without going into detail, we see the following problems: 1) Inadequate solvency safeguards for the businesses and their employees that participate. 2) Inadequate regulatory oversight and control by the Insurance Department. 3) No level playing field with other financing mechanisms such as HMO's and health insurance. 4) These new health service networks would not be subject to all the insurance laws and regulations including the extensive small group health reforms passed beginning with HB 2001 and including SB 561.

If our reading of this legislation is correct, these new health service networks and this alliance would not be subject to the guaranteed issue and guaranteed renewable requirements now placed on insurance companies for small employer group coverage. Nor would they be subject to requirements for portability of preexisting conditions coverage, compression of rates towards community rates, COBRA and the Kansas equivalent on continuation and conversion, standard policy coverages, mandates of health providers and health coverages and a host of other laws and regulations.

Nor would there be a level playing field with insurers. These new health service networks do not appear to be subject to the state's 2% premium tax on foreign companies and 1% on domestics, to regulatory oversight costs or to routine examination by the Kansas Insurance Department or any other entity. Has a fiscal note been prepared for the

PH+W
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attm #13-3
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loss of premium tax revenue?

We are very concerned about new Section 21 which seems to promise universal health insurance for all Kansans, but with no mention of how we would pay for it.

We also support meaningful tort reform as a means to begin controlling health care costs. We urge the House to support SB 761 which reenacts collateral source following the Kansas Supreme Court decision last year invalidating our 1988 reform because of the $150,000 threshold.

We think it is premature for Kansas to act before Congress on this broad an issue. Kansas is not an island. We cannot afford to lose jobs and economic development to other states because of our health care system. While this bill probably would not have that immediate impact, it is certainly taking us a long way down that road.

We urge the committee not to report the bill favorably. We would be happy to answer questions or provide additional information.

P H & W
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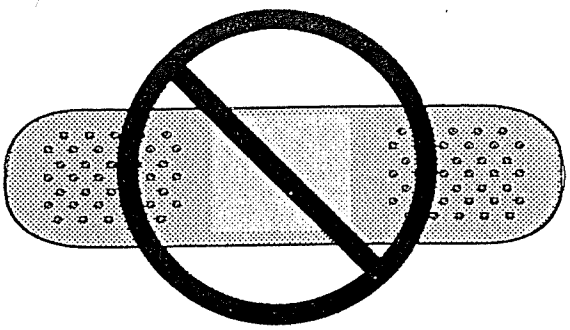
Attm # 13-4
Pg 4 of 4



No more Bandaid attempts at health care reform!

Health Care Reform Coalition

KANSAS HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE
House Bill No. 3075
March 23, 1994

testimony by: Michael R. Todd
Health Care Reform Coalition
2011 Miller Dr.
Lawrence, KS 66046
(day) 913-841-0333
(evening) 913-843-2428

Thank you, Chairperson Flower and members of the Public Health and Welfare Committee, for allowing me to testify in support of House Bill No. 3075. My name is Mike Todd and I am speaking on behalf of the Health Care Reform Coalition, a group representing over 100 agencies in Kansas that advocate for people with disabilities and seniors. Enclosed with my testimony you will find a copy of our Statement of Principles, which are elements we feel should be included in any health care reform effort.

The Health Care Reform Coalition, realizing that House Bill No. 2699 is probably dead this session, supports HB 3075, with some modifications. We feel the Kansas Health Council, outlined in Section 2, should be expanded to five members, with at least one member being a representative of consumers not connected to providers or insurance companies. We do support allowing one representative of providers and insurance companies to be members of the Council, but feel that one member should also be a consumer representative. We feel that a council appointed by the Governor would reduce the possibility of influence by special interests and be more representative of all people of Kansas than a legislative committee.

Page 3, Section 6 allows the Council to establish advisory committees to study certain subjects related to health care. The Health Care Reform Coalition supports this, and asks that you include language that mandates consumer representation on all of these advisory committees. We also support the provision of mileage reimbursement for members of these advisory committees. Unlike Senate Bill No. 816, this allows people outside of northeast Kansas to not be penalized for serving as members of these committees.

Page 6, Section 13 directs the Kansas Health Care Purchasing Cooperative to develop a health care plan for "selected Kansans." We would ask, to ensure freedom of choice of provider, that you mandate an option to all of a fee-for-service plan.

Page 10, Section 24(c), calls for the cooperative to designate by rules and regulations those persons who may participate in the state health care benefits program. We would suggest that this

P H & W
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attm #14

include all Kansans by January 1, 1998. This would move our state toward universal coverage.

Page 12, Section 26 states that the Cooperative may contract with health maintenance organizations. Again, we ask that language be included in the bill to mandate an option for a fee-for-service plan to all who participate in this plan. This ensures freedom of choice of provider.

The Health Care Reform Coalition supports House Bill No. 3075, with our suggested changes.

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attm #14-2
Pg 2 of 5

PRINCIPLES OF HEALTH CARE REFORM

Reflecting the Needs of People with Disabilities and All Citizens

Whereas one in every six Americans experiences a disability; and

Whereas the needs of people with disabilities provide a litmus test for the effectiveness of the health care system; and

Whereas the health care needs of people with disabilities are not currently being met;

We, the undersigned, *being organizations that advocate for the needs of people with disabilities* and/or groups with similar needs, do hereby declare our solidarity on the following basic principles that must be included in health care reform:

- Universal and lifetime coverage, with no exclusions for pre-existing conditions, no caps on services, and portability.
- Comprehensive coverage to include: long term care; acute and preventative services; community-based services; prescription drugs; habilitative services and equipment; personal assistance services; mental health coverage; and durable medical equipment.
- Cost containment, affordability, and community rating
- Choice of physicians
- Quality assurance
- Simplicity and efficiency
- Consumer involvement in all phases of development and implementation

Signed this 7th day of February, 1994.

Martha Galehart
Kansas Commission on Disability Concerns

Gina McDonald
Kansas Association of Centers for Independent Living (KACIL)

Glen Haney
Kansas Rehabilitation Services

Ivan Rhys
Kansas Planning Council on Developmental Disabilities

Lucille Parli
Kansas Association for the Blind and Visually Impaired

Terry Larson
Kansas Alliance for the Mentally Ill

Patricia A. Seidel
Families Together, Inc.

Topeka AIDS Project

Thomas W. Hamm
Kansas Association of Rehabilitation Facilities

Michael D. Dodd Jr. P. H+W
Independence, Inc.

P H+W
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~~Pg 3 of 5~~

Michael Byington
Kansas Deaf-Blind Program

Marty Wooten
Southeast Kansas
Independent Living, Inc.

Independent Living Center of
Southcentral Kansas, Inc.

Brian M Atwell
Living Independently in
Northwest Kansas, Inc.

Full Citizenship, Inc.

Thomas L. Robinson
Western Kansas Association
of Concerns of the Disabled

James W. Blume
Developmental Services of
Northwest Kansas, Inc.

Mark D Elmore
Johnson County Mental
Retardation Center

Ted Folsin
Northview Developmental
Services, Inc.

Rainbows United, Inc.

Lois Reid
Achievement Services for
Northeast Kansas, Inc.

Don Pendergast
Arrowhead West, Inc.

Don L. Andrews
COF Training Services, Inc.

Judy Hearn
Kansas Elks Training Center
for the Handicapped

Futures Unlimited, Inc.

Arlene Larson
Sheltered Living, Inc.

Bethphage Mission of the

Kansas Association of
Mental Health Centers

Barb Jones
Accessing Southwest
Kansas, Inc.

Jan O'Rourke
The WHOLE PERSON, Inc.

Bruce W. Warren
Kansas Commission for the
Deaf and Hard of Hearing

Lisa Paslay
The ARC of Kansas

Jim Zaiser
The Capper Foundation

Cerebral Palsy Research
Foundation of Kansas, Inc.

Occupational Center of
Central Kansas, Inc.

Linda Lock
Brown County Developmental
Services, Inc.

Dr. Hay Allen Jr.
Wyandotte Developmental
Disabilities Services

Tri-Valley Developmental
Center, Inc.

Lakemary Center, Inc.

Starkey, Inc.

Alice M Hackney
Nemaha County Training
Center, Inc.

STEPS, Inc.

Jack Sturman
Tri-Ko, Inc.

William V. Fleming
AARP Kansas State
Legislative Committee

PNW
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Families USA Foundation

Douglas County/Lawrence
Advocacy Council on Aging

Older Women's League,
Lawrence

Health Care Access Inc.

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3-23-94
Attm # 14-5
~~pg 5 of 5~~

KANSAS ASSOCIATION OF CENTERS FOR INDEPENDENT LIVING

3258 South Topeka Blvd. ~ Topeka, Kansas 66611 ~ (913) 267-7100 (Voice/TT)

Gina McDonald
Executive Director

TESTIMONY TO THE HOUSE COMMITTEE
ON
PUBLIC HEALTH AND WELFARE

REPRESENTATIVE JOANN FLOWER CHAIRPERSON

MARCH 23, 1994

Member agencies:

ILC of Southcentral Kansas
Wichita, Kansas
(316) 838-3500 V/TT

Independence, Inc.
Lawrence, Kansas
(913) 841-0333

Independent Connection
Salina, Kansas
(913) 827-9383

LINK, Inc.
Hays, Kansas
(913) 625-6942 V/TT

Resource Center for
Independent Living
Osage City, Kansas
(913) 528-3105 V/TT

ILC of Northeast Kansas
Atchison, Kansas
(913) 367-1830 V/TT

The WHOLE PERSON, Inc.
Kansas City, Missouri
(816) 361-0304 V
(816) 361-7749 TT

Topeka Independent
Living Resource Center
Topeka, Kansas
(913) 267-7100 V/TT

A.S.K., Inc.
Dodge City, Kansas
(316) 225-6070 V/TT

SEK Independent Living
Parsons, Kansas
(316) 421-5502 V
(316) 421-6551 TT

My name is Mike Oxford, I work for the Kansas Association of Centers for Independent Living (KACIL). KACIL represents Independent Living Centers which provide services and advocacy for civil rights for people with disabilities in Kansas.

KACIL supports the concept and apparent intent of House Bill 3075, particularly when viewed as a companion to House Bill 3076. House Bill 3075 would set up structures with the purpose of exploring methods to provide health insurance to more people, including member agencies of KACIL and other small businesses, both for profit and no-for-profit. In fact, this bill states that one of its purposes is to ensure adequate, affordable health care for <u>all</u> Kansans. This is a forward thinking and highly commendable goal. It holds out a high promise which I hope is kept.

There is two areas of concern which I would like to address, however. The first involves the make-up of the Kansas Health Care Purchasing Cooperative. Its makeup should include members not affiliated with a governmental entity, or with education. The cooperative would be more representative if it included other types of entities such as small businesses and not-for-profit agencies. The list included in New Section 10 outlining consumers to serve in the advisory committees provides examples of whom should be included. This would provide fairer representation with the ability to vote on issues as opposed to just providing input to the decision making process in an advisory capacity.

The second concern involves the advisory committees make-up in New Section 10. What exactly is approximately 50% consumer participation - 35%, 45%, 60% - ? If a consumer focus is the intention, then the language should specify that a majority of the members of the advisory committees should be consumers. New Section 10 (b) (1), lines 16 and 17 should be amended to read, "The advisory committees under this section shall be composed of persons <u>a majority</u> of whom shall be consumers....".

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Attm #15

Please consider these concerns in your deliberations about House Bill 3075. Addressing these concerns within the context of this bill would be a tremendous stride toward making affordable, adequate health care for all Kansans a reality and not just a noble intention.

I appreciate the opportunity to appear before you and present my thoughts. I would be happy to answer and questions or address any concerns.

PH+W
3-23-94
attm # 15-2
~~Pg 2 of 2~~

THE LEAGUE
OF WOMEN VOTERS
OF KANSAS

March 23, 1994

TO: Representative Joann Flower
Chairperson, House Committee on Public Health and Welfare
Room 426-S
Statehouse, Topeka

FROM: Edward Rowe, member of lobby corps, LWV

RE: Comments on HB 3075, which would establish the Kansas Health Council and the Kansas Health Care Purchasing Cooperative

The League of Women Voters looks for the following points in any health care proposal: universal coverage; comprehensive benefits package to cover preventive, primary, acute services, and chronic and long-term needs; and cost-containment measures.

We hope you will pass a Kansas health care bill this year. We think it's essential for Kansas to have an agency in place with people ready to work as soon as Congress acts.

Our first choice would have been the 403 Commission Plan (HB 2699). Our people looked at that plan and found it was close to League's national position. While it is not clear that HB 3075 addresses all of the key points in the first paragraph, it would establish a Kansas agency capable of responding quickly when the federal legislation comes. Kansas has been a leader on many national issues. Let's position ourselves to lead on this issue, too.

cc: members of the Public Health Committee

PH&W
3-23-94
Attm #16

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1504
(913) 296-2436
FAX (913) 296-0231

Joan Finney
Governor

Gloria M. Timmer
Director

March 18, 1994

The Honorable Joann Flower, Chairperson
House Committee on Public Health and Welfare
Statehouse, Room 426-S
Topeka, Kansas 66612

Dear Representative Flower:

SUBJECT: Fiscal Note for HB 3075 by House Committee on Appropriations

In accordance with KSA 75-3715a, the following fiscal note concerning HB 3075 is respectfully submitted to your committee.

HB 3075 would implement a system of providing health care services to citizens of the state. It would establish the Kansas Health Council to set policy regarding health benefits to be provided to the state's residents. Also, the bill would create the Health Care Purchasing Cooperative to establish standards, make recommendations and provide for the purchase of health care services for selected Kansans. Advisory committees would also be created to advise the Cooperative.

The bill would create a three-member Kansas Health Council to be appointed by the Governor. No more than two members of the Council would be of one political party. After initial staggered appointments, the members would serve four-year terms. Salaries for the Council members would be set by the Governor. The bill would also establish the Executive Director with a salary approved by the Governor. Other positions could be created by the Council, as needed.

The Council would perform a number of functions relating to health care policy. The Council would serve as the official state agency to cooperate and interact with agencies of the federal government responsible for health care reform. Taking into account delivery systems in place or contemplated, the Council would work

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Attm #17

cooperatively with relevant state and federal agencies, health care providers, payers and consumer groups to develop a comprehensive and integrated health plan for Kansans. The bill would envision implementation of such a plan by July 1, 1998. The council would also be responsible for ensuring that the state comply with federal minimum benefit requirements. It would also analyze and make recommendations concerning the state health care database and perform a number of health policy functions detailed in the bill.

The Council would be authorized to establish, within appropriations, advisory committees to assist it in exercising its duties. It would be authorized to apply for, receive and administer public and private grants.

The bill would establish the Health Care Purchasing Cooperative to develop and administer health care benefits in the state. The Cooperative would comprise the Commissioner of Insurance, the Secretary of Administration, the Secretary of Health and Environment and six other members appointed by the Governor. These six members would be drawn from specified groups of current and former public employees and representatives of small businesses. The Cooperative's non-ex officio members would serve four-year terms. A member of the Cooperative would be elected president each January.

The bill would create three advisory committees to the cooperative. One would be an advisory committee on small business. Two committees would include members representing specified groups, with approximately one-half representing health care providers and one-half drawn from consumers of health services.

The Health Care Purchasing Cooperative and its advisory committees would maintain an ongoing study and review of the State Health Care Benefits Program, the cafeteria plan and the State Health Care Services Purchasing Program. Also, the Cooperative would be authorized to enter into agreements with other states (including Canadian provinces and Mexican states) providing for administration of health benefits. Such agreements would require the Governor's approval.

The Cooperative would develop a health care plan for selected Kansans that embodies managed care elements described in the bill. The Cooperative would adopt the minimum package of health care benefits that conforms to federal requirements and the recommendations of the Health Council. This basic minimum package would apply to consumers, providers and health care networks. The bill would allow the Cooperative to require health services providers to meet certain financial conditions prior to contracting to provide services through the Cooperative. The Cooperative would also develop a quality assurance program to promote medical services in the state.

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Attm #17-2
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Under the bill, the Cooperative could contract and provide medical services for companies of between 3 and 100 workers. "Company" would be defined as any entity doing business in the state. The Cooperative would also develop plans to contain health cost increases and provide for the resolution of complaints regarding its activities. The Cooperative would cooperate with the Department of Health and Environment to ensure the delivery of quality public health services.

The bill would abolish the State Health Care Benefits Commission and transfer its duties and responsibilities to the Health Care Cooperative. Also, it would establish the State Health Care Services Purchasing Program to purchase health services for consumers other than state agencies. The bill would provide that Medical Assistance clients of the Department of Social and Rehabilitation Services could be served by a benefit package purchased through the Health Services Purchasing Program.

Passage of the bill would require additional administrative expenditures totaling $1,158,991 beyond the amounts included in the *FY 1995 Governor's Budget Report*. Since the bill does not provide an alternative funding source, the expenditures would presumably come from the State General Fund.

Additional expenditures would be required to implement provisions of the bill creating the Health Services Council and supporting staff. Expenditures would include salaries and wages for the three-member council and three other professional positions as well as support costs. Substantial contractual services would be required to assist the Council in establishing a basic benefit package that meets the state's needs and conforms with federal requirements. Expenditures would also support advisory committees established by the Council.

An analysis of the Council created in the bill, compared to other similar state entities, produces estimated first-year expenditures of $781,721. The amount would include $508,021 for salaries and wages for 6.0 FTE professional positions and 3.0 additional clerical support positions. Salary amounts for each position are comparable to amounts paid to the Kansas Corporation Commission members and staff. Estimated expenditures also include $273,700 for operating expenditures. The estimate includes $75,000 for the purchase of equipment, which would not be required in subsequent fiscal years.

Implementation of the Health Care Purchasing Cooperative provisions of the bill are estimated at $377,270. This amount is based on estimates of the Department of Health and Environment to implement SB 521 enacting the Kansas Health Alliance. The estimate includes $243,111 for salaries for 7.0 FTE positions and per diem payments to board members. Also, the estimate includes $134,159

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attm #17-3
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for other operating expenditures. Capital outlay expenditures of $53,000 would not be repeated in future years.

The Governor's recommendations for FY 1995 contain expenditures of $343,198 and 4.0 FTE expenditures for health benefits administration. Under provisions of the bill, this function would be transferred to the Health Care Purchasing Cooperative. The transfer of the function to the Cooperative would require no new expenditures beyond amounts included in the Governor's recommendations and could partially offset amounts detailed above.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

3075.fn

PH+W
3-23-94
Attm #17
~~Pg 4 of 4~~

State of Kansas

Joan Finney Governor

Department of Health and Environment

Robert C. Harder, Secretary

MEMORANDUM

Date: March 23, 1994

To: Members of the House Public Health and Welfare Committee

From: Robert C. Harder, Secretary

Re: Health Care Reform

I continue to be concerned about health care reform. Without spending a lot of time on numbers in need; I would simply say that any person or family in need of medical services and not able to get the service is a person/family with a medical problem.

HB 3075 is in two parts; the first deals with a comprehensive health care reform mechanism. Dr. Roy will speak to that part of the bill.

The second major part of the bill deals with setting up a purchasing cooperative for the purpose of purchasing medical services. Such a purchasing coop could cover the existing state purchasing of health insurance as well as cities, counties, school districts and some non-profit organizations. At some point, small businesses should be brought into the coop.

In the interest of making maximum use of dollars being spent, consideration should be given to having the purchasing coop buy medical services for all state agencies.

Ultimately, the make-up of the governing board will need to be changed to represent the parties for whom health insurance is being purchased.

I am prepared to cooperate with any persons or groups in the interest of continuing this important discussion related to health care reform.

PH&W
3-23-94
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