Approved: 3-30-94
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 15, 1994 in Room 526-S of the Capitol.

All members were present except:

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

Conferees appearing before the committee:

Representative Dennis McKinney
Tom Bell, Kansas Hospital Association
Chip Wheelen, KMS Director of Public Affairs
Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine
Robert C. Harder, Secretary, Kansas Department of Health and Environment

Others attending: See attached list

Hearing on HB 2709 - Health care provider cooperation act

Representative Dennis McKinney addressed the Committee in support of **HB 2709** which would enact the Health Care Provider Cooperation Act. The bill would provide that cooperative agreements approved under the Act articulate and implement the policy of the state to improve and protect the quality and availability of health care to Kansas citizens, and that continued active supervision by the state over all aspects of such agreements will provide protection to the public offsetting the loss of protection otherwise provided by competition. Representative McKinney noted that rural hospitals are not only cooperating more among themselves, but they are linking up with larger tertiary care centers which are usually privately owned and would remove obstacles in regard to local efforts. (Attachment 1)

Staff briefed the Committee on the bill which was introduced by the Joint Committee on Health Care Decision for the 1990s during the interim that would assist providers in meeting the challenges confronted from health care reform on one side and federal anti-trust laws on the other. It was noted that pharmacists and optometrists are not included in the bill since they are not defined as health care providers in K.S.A. 65-4921.

In answer to a member's question regarding cooperative agreements, staff noted that the only agreements the secretary of health and environment would maintain on file under Sec. 5 are those where a certificate of public advantage has been issued under this Act and would not include any agreement entered into prior to the effective date of the Act. In regard to the oversight requirement, the secretary would be involved in making determinations based upon any applications for agreements and set the fees. Secretary Bob Harder acknowledged there is a fiscal note and will provide more information to the Committee on what fees would be needed to cover the cost. Concerns were also expressed that the committee members, as referenced in the bill, would not be paid compensation, subsistence allowances, mileage or other expenses for attending meetings.

Tom Bell, KHA, appeared in support of **HB 2709** and noted the bill is similar to Maine legislation. It was pointed out that anti-trust laws make joint conduct suspect, so whenever conduct is collaborative or cooperative in any way, there is the potential that anti-trust laws are going to be involved. At the same time there are other agencies of the federal government that have encouraged hospitals and other providers to be as efficient as possible, and that the solution to this problem lies at the federal level. (Attachment 2)

Chip Wheelen, KMS, addressed the Committee in support of the provisions of **HB 2709** but noted they would prefer exemptions from prosecution under the federal anti-trust laws. Mr. Wheelen commented they are also awaiting an act by Congress to provide some protection that would allow health care providers to collaborate and cooperate for the sake of being more cost-effective. (Attachment 3)

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

Harold Riehm, KAOM, appeared before the Committee with reserved support for the bill, and noted that osteopathic physicians are always concerned about agreements among providers that may lead to their exclusion and the loss of physician choice by patients. (Attachment 4)

Bob Williams, Kansas Pharmacy Association, and Gary Robbins, Kansas Optometric Association, both appeared before the Committee and asked that their respective organization's profession be included under the health care provider definition in the bill.

Hearing on HB 2740 - Rules and regs for laboratories testing for controlled substances and metabolites thereof

Robert C. Harder, KDHE, appeared in support and submitted written testimony on **HB 2740.** Dr. Harder noted that the intent of the bill is to avoid duplication of state and federal regulatory requirements for some medical laboratories in Kansas, and assuming that federal regulation of clinical laboratories will remain intact through the restructure associated with health care reform, Kansas requirements for laboratories performing HIV tests and syphilis serology tests can be eliminated as proposed in this bill. However, non-forensic urine screens for drugs of abuse are not currently included in federal regulatory requirements and thus should be retained under state legislation -- for this reason Dr. Harder recommends that state regulatory oversight should be retained to assure the accuracy of urine drug screens. (Attachment 5)

Concern was expressed by staff regarding the confidentiality of laboratory results obtained under CLIA as referenced in Sec. 3, and that the bill should include confidentiality language to include former employees of the state laboratories as well as those laboratory employees that are regulated by the state. Dr. Harder noted that he would research the issue and provide more information to the Committee.

Discussion of HB 3028 - Accessibility standards; conformance with Americans with disabilities act

The Chair called the Committee's attention to a letter from the Attorney General's office regarding questions and concerns that were raised at the previous Committee meeting. (Attachment 6) The Chair requested staff to prepare language in the bill that would incorporate specific definition relating to "facility." Staff also noted that on page 8, line 9, reference to both Title I and Title III should be left in the bill.

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for March 16, 1994.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH & WELFARE DATE: 3-15-94

NAME	ADDRESS	COMPANY/ORGANIZATION
ALAN COBB	WICHITA	WICHITA Hospices
Jennifer Roe	Topeka	Senate Staff
Brenda Cron	"	AIA Kansas
Stacey Thompson	Topeka	KHA
HAROLD RIETHA	TOPEKA	KAOM
Tom Bell	"	KHA
Dennis McKinney		House
Roger Carlson	KDHE Topeka	KDHE
Chip Wheelen	Topeka	KS Medical Soc
Bill Sneed	Topeka	KLRD
SHELBY SMITH	WICHITA	KPMA
LINDA McGILL	TOPEKA	PETE McGILL & ASSOC.
Kathy Pearden	PO Box 206 Topeka	Ks Assn for Medically Underserved
~~KSDA~~ David Hanzlik	Topeka	KS Dental Assn
Rich Chrisman	KC	Health Midwest
Joe Turpin	Topeka	KCA
GARY Robbins	Topeka	Ks Optometric Assn
LARRY MAGILL	"	KAIA
Nancy Zogleman	KC	Pfizer

STATE OF KANSAS

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REPRESENTATIVE, 108TH DISTRICT
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ENERGY & NATURAL RESOURCES
TAXATION
TRANSPORTATION

March 15, 1994
Testimony to Senate Public Health & Welfare Committee

Thank you for the opportunity to testify on HB2709 regarding hospital cooperative agreements. Naturally I am interested in this legislation because of the doors I believe it would open for rural hospitals.

As I understand current federal law, some antitrust protection is already afforded to public hospitals. And most rural hospitals are publicly owned.

However, rural hospitals are not only cooperating more among themselves, but they are linking up with larger "tertiary care centers" which are usually privately owned. The most exciting new development in this area is the extension of interactive video which now exists in most rural Kansas communities. Interactie video will allow rural hospitals to keep patients in their "home" hospital and access specialists through the interactive video link to the larger urban hospital.

In addition, rural hospitals are getting into areas once thought to be the domain of private enterprise. Because of changes in the medical industry doctors in rural communities usually no longer own the clinic facilities. These are now usually owned by the cities or counties and managed by the hospital management. The doctors are hired quite often by the hospital management on a productivity contract after being given large first year guarantees and other major benefits.

Still further, because of the difficulty in hiring doctors in rural areas we are starting to discuss setting up multi-county family practice

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corporations. These could allow greater sharing of doctors and health care professionals and more ability to locate and recruit professionals.

Attached is a copy of a Wall Street Journal article discussing problems posed under current federal law.

The purpose of legislation to facilitate cooperative agreements is to remove obstacles to local efforts to help ourselves. While we are facing great challenges, there is optimism in my area that we can adapt and overcome the threats to high quality affordable and accessible rural health care.

Thank you very much for your time and attention.

KETPLACE

Advertising: *Racy 'NYPD Blue' looks to be a tough sell for ABC* *Page B5.*

Medicine: *Study links breast cancer treatment to lung disease risk* *Page B8.*

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Disputes Pit HMOs Against Doctors

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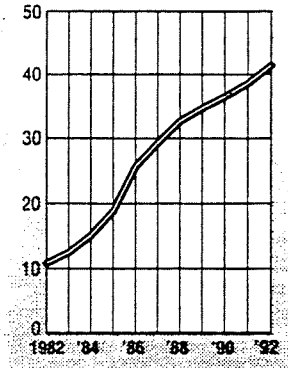

Sources: Health Affairs and Group Health Association of America

But Clash With M.D.s
Recent cases and outcomes

- **U.S. VS. AARON LANOY ALSTON, ET AL.:** Arizona dentists were accused of conspiring to fix prices; lead defendant pleaded no contest in January 1993.
- **U.S. VS. MASSACHUSETTS ALLERGY SOCIETY:** Society was accused of conspiring to fix prices paid by HMO; it settled case in 1992 by accepting limits on its negotiation tactics.
- **IN RE: SOUTHBANK IPA:** Jacksonville, Fla., obstetricians were investigated by FTC on charges of anticompetitive behavior; they settled case in 1991 and agreed to disband joint marketing group.

clearing the way for managed-care plans to operate in the face of doctors' opposition. He added: "Continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care reform."

HMOs portray themselves as the vulnerable ones, needing federal antitrust support. "What's disturbing to me is a push by providers to band together and exclude managed care," says David Simon, general counsel of U.S. Healthcare Corp., an HMO based in Blue Bell, Pa.

"I believe the Justice Department is getting more aggressive in trying to find out about these issues and pursue them," Mr. Simon says. But he contends that it's difficult to catch doctors in the midst of anticompetitive plotting. "Nothing is done overtly," Mr. Simon asserts. "It's done quietly, in hospital cafeterias."

Doctors and their lawyers contend that the balance of price-negotiating power has shifted too far toward HMOs. "We want an ability for physicians to have viable collective negotiations [with HMOs], so we can have a level playing field," says Kirk Johnson, chief legal counsel for the American Medical Association. "We aren't talking about an ability for doctors to boycott, or engage in price fixing. We're just talking about fairness.

"Health plans now are able to speak for hundreds of thousands of people," Mr. Johnson says. "Maybe professionals ought to be able to respond to that in a collective way." The current disparity, in which health plans can use their market clout but doctors can't, is "very disturbing," he says.

Antitrust cases so far provide some support for both sides. In at least five instances since 1990, the Justice Department or the FTC has won either court verdicts or settlements that have barred doctor groups from anticompetitive practices. The cases range from alleged price fixing by Massachusetts allergists to an alleged boycott of an unpopular HMO by Florida obstetricians.

But several cases also protect doc-

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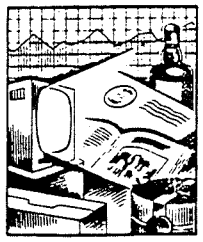
New Rules Let Hospitals Start Joint Ventures

By EDWARD FELSENTHAL
Staff Reporter of THE WALL STREET JOURNAL

Hospital executives in five states are doing something that only a few years ago would have been unthinkable, and possibly illegal. They're talking to one another.

Despite concerns about inhibiting competition, more states are allowing hospitals to negotiate joint ventures that could help reduce empty beds and underused services. Just talking about such ventures might once have violated antitrust laws, which are designed to promote competition by preventing collusion and price fixing. But under newly enacted legislation in Maine, Minnesota, Ohio, Wisconsin and Washington, hospitals pursuing many kinds of cooperative projects can get protection from antitrust enforcement. Similar laws are pending in six other states and in Congress.



"Before this law was passed, if you got two hospitals together, somebody in the room was going to say, 'Wait a minute, antitrust, everybody clam up,' " says Donald McDowell, president of Maine Medical Center in Portland, the state's largest hospital.

Courts will allow a state to grant exemptions from federal antitrust scrutiny, as long as the state actively supervises any anticompetitive ventures. Wisconsin's reform, for instance, sets up a screening process through which hospitals and other health-care facilities can petition state

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OVER

ENTERTAINMENT

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LAW

New Rules Are Allowing Hospitals To Engage in Some Joint Ventures

Continued From Page B1

officials for authorization to share personnel, patients or services. The officials are to issue their approval if they decide the benefits of a proposed venture substantially outweigh the disadvantages of any reduction in competition. Authorization can be revoked later if the officials monitoring the venture change their minds.

The first state to change the rules on hospital cooperation was Maine, which enacted its law last year. Almost immediately, hospitals all over the state leapt into negotiations. In September, Northern Cumberland Memorial Hospital, a 40-bed hospital in Bridgton that hadn't been able to recruit a pediatrician, formed a joint venture with a 50-bed hospital 20 miles away. The venture established a pediatric practice to serve all of western Maine. Meanwhile, 10 Maine hospitals are considering collectively expanding their mental-health services. And three Portland facilities have discussed creating a joint laboratory.

By relaxing antitrust scrutiny and promoting cooperation, the five states have challenged a tenet of faith in current efforts to control health costs: the idea that more-intense competition will reduce prices. The states' actions also could collide with proposals by President Clinton's health-care task force, which is expected to recommend introducing new competition to the medical market.

But many supporters of the antitrust reforms contend that competition is part of the problem, and not the solution. Competition, they argue, has led to a kind of medical arms race in which even small hospitals try to offer patients all the latest technology. The hospitals then have to raise prices to cover the high costs of the technology. "Competition has had a long time to work," says Mr. McDowell. "The more we've competed, the more we've driven up the costs."

Even if more states pass antitrust exemptions, hospitals in many areas may choose not to cooperate with one another. Most of the states that already have passed reforms have an abundance of small rural hospitals struggling to stay afloat. In big cities teeming with prospective patients, large hospitals could find the need for collaboration less urgent.

Big-city hospitals often are "committed to a kamikaze survival instinct," says Mr. McDowell. "If I have a long-range strategic plan that says I'm going to steal your market share, it's very hard for me to sit down and talk with you about cooperation."

Some supporters of hospital antitrust exemptions believe that encouraging more cooperation in health care actually will promote competition in the long run. "It isn't a question of competition not working," says Thomas Campbell, an antitrust specialist at law firm Gardner, Carton & Douglas in Chicago. "It's a question of whose brand of competition we're talking about." Mr. Campbell contends that joint ventures and mergers make hospitals more efficient and therefore better able to compete for patients by offering cheaper care.

Federal officials responsible for antitrust enforcement remain wary of hospitals' intentions and warn that some facilities, if unwatched, may collaborate in ways that harm consumers. They also insist that broad antitrust exemptions aren't necessary because the government has challenged only five of the more than 200 hospital mergers that took place between 1987 and 1991. "Government action has been very precise," says Mary Lou Steptoe, acting director of the Federal Trade Commission's Bureau of Competition. "It's been a scalpel and not a bludgeon, and yet the talk out there is as if we are running out there with a bludgeon and stopping every hospital merger."

But antitrust lawyers and hospital executives say the government's five prosecutions have been vigorous enough to frighten many hospitals from talking about cooperative ventures. "It's a little disingenuous to say we've only gotten away with robbing five banks," says Mr. Campbell. Once word gets out, he says, "everyone locks their windows."

1-4

Colo., Texas laws offer relief

Colorado and Texas are the latest two states to pass laws extending antitrust relief to hospitals that engage in collaborative ventures.

With last month's passage of the laws, at least seven states now offer hospitals similar antitrust protection. The others are Maine, Minnesota, Ohio, Washington and Wisconsin. Similar bills are pending in a number of other states.

The hospital industry, led by the American Hospital Association, has argued that antitrust laws and enforcement policies have barred and inhibited beneficial collaborative arrangements among hospitals. However, recent business activity and statements by AHA executives indicate that collaborative ventures among hospitals and between hospitals and other providers are flourishing despite the antitrust laws and enforcement policies (Oct. 12, 1992, p. 26).

Regardless, the industry has been lobbying for antitrust relief at both the federal and state levels. While some skepticism remains among federal officials, state lawmakers appear sympathetic to hospitals' cause and are passing hospital antitrust protection measures.

In Colorado, the Hospital Efficiency and Cooperation Act took effect on July 1. The state House of Representatives passed the bill on May 11 by a 58-4 vote; the state Senate passed the bill on April 15 by a 28-3 vote. Colorado Gov. Roy Romer signed the bill into law on June 8.

The new law, written by and introduced on behalf of the Colorado Hospital Association, creates an 11-member "healthcare agreements board" to review applications from any of Colorado's 76 hospitals seeking collaborative arrangements.

The board can approve applications from hospitals whose ventures are deemed to provide certain benefits, such as improving access or quality, reducing costs or increasing efficiency. Approved ventures would be exempt from state antitrust laws. The board also will review annual reports from hospitals and can terminate agreements that aren't meeting their promised goals.

The law achieves a number of objectives aside from offering hospitals legal safety, said Larry Wall, president of the Colorado Hospital Association.

The objectives include sending a message to hospitals that they should consider collaboration rather than competition, said Mr. Wall, who added, "This precludes hospitals from using antitrust as a reason not to work together."

Mr. Wall

The new law, however, doesn't specifically mention mergers or acquisitions as types of protected activity. Mergers and acquisitions were included in the CHA's original bill but were dropped during the legislative negotiations.

"We would have liked to keep mergers in, but we're comfortable with the change because many mergers would need to be reviewed by the Justice Department anyway," Mr. Wall said.

Meanwhile, Texas Gov. Ann Richards signed legislation on June 12 that tries to insulate hospitals from federal antitrust law by creating a way to certify that the benefits of collaboration outweigh any anti-competitive risks.

The measure passed the state Senate on May 26 by a voice vote; it passed the state House on May 28, also by a voice vote. The new law will take effect on Sept. 1.

Under the law, any of Texas' 511 hospitals can apply for a "certificate of public advantage" from the state health department. To obtain a certificate, hospitals will have to demonstrate by "clear and convincing evidence" that their proposed ventures do such things as improve access and quality, improve hospitals' cost efficiency and avoid duplication of hospital resources.

Like Colorado's law, the new Texa statute doesn't apply to hospital merg ers or acquisitions.

The state attorney general's office wi conduct a simultaneous review of th ventures to determine whether th anti-competitive risks of the deals ou weigh the community benefits. The a torney general can advise the health d partment against granting certificat or, if certificates are granted, can sue t hospitals anyway.

The law is intended to insulate hos tals from federal antitrust scrutiny u der the legal doctrine of "state action i munity." Under the doctrine, activit mandated by the state and actively s pervised by the state are immune fr federal antitrust laws.

Under the Texas law, the health partment and attorney general have authority to terminate a hospital's c tificate of public advantage if a vent isn't living up to its promises.

The Texas Hospital Association hel draft and lobbied for the legislat

—David Burda

Iowa hospitals submi additional merger dat

Attorneys for two merging Iowa ho tals are scheduled to meet with Jus Department antitrust investiga this week to discuss the competitiv fects of the hospitals' consolidation

The July 9 meeting in Washin follows the completion last week o submission of additional financial utilization documents to the Ju Department by the two Des Mo hospitals, 710-bed Iowa Metho Medical Center and 319-bed Iowa theran Hospital.

The hospitals announced merger in February and filed th quired pre-merger notification ments with the government in Ap May, the Justice Department iss "second request" for information the two hospitals regarding transaction.

A second request for information cally signals that a proposed mer acquisition is undergoing a thorou amination for anti-competitive effe

Spokesmen for the hospitals, merger will give them control of the nearly 2,000 staffed hospita in Des Moines, have expressed dence the government will gi hospitals antitrust clearance 24, p. 13).

Shalala OKs 'safe harbors' volume 2

HHS Secretary Donna Shalala signed off on the long-awaited second set of Medicare "safe harbor" regulations last week, forwarding them to the White House Office of Management and Budget for a final review, said a spokeswoman for HHS' inspector general's office.

In January, the Clinton administration withdrew the regulations days before their expected publication along with all non-emergency federal regulations (Feb. 1, p. 10).

The regulations are expected to insulate certain hospital physician recruitment activities from the anti-kickback provisions of the Medicare and Medicaid fraud and abuse statutes.

KA HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

Date: March 15, 1994

To: Senate Public Health & Welfare Committee

From: Kansas Hospital Association

Re: **Health Care Provider Cooperation Legislation; HB 2709**

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of HB 2709. We support such legislation because it could be beneficial in promoting more collaboration among health care providers in our state.

At the heart of this discussion are the antitrust laws and their effect on collaborative efforts among health care providers. The Sherman Act (15 U.S.C. § 1), a federal law, prohibits joint action that unreasonably restrains trade. The Act also prohibits monopolization and attempted monopolization. Another federal law, the Clayton Act (15 U.S.C. § 13), prohibits, among other things, mergers or joint ventures that may lessen competition or create monopolies. These laws are enforced by the Federal Trade Commission and the Department of Justice. In addition, state attorneys general have standing to enforce the federal antitrust laws under the Clayton Act.

Most advocates of some type of health care reform agree on at least one point: increased cooperation among health care providers is vital for improving cost efficiency and patient access. Despite this agreement, health care providers are receiving mixed messages from the federal government. The Department of Health and Human Services (HHS) encourages providers to increase efficiency, avoid duplication, and reduce costs--goals that can be achieved through greater provider collaboration. At the same time, the Department of Justice (DOJ) and Federal Trade Commission (FTC) indicate that activities designed to achieve these goals may be at risk under the federal antitrust laws. Many arrangements which common sense indicates are appropriate from a health care perspective may be prohibited by the antitrust laws.

The antitrust laws were not intended to prevent, or even inhibit, vital health care services from being provided to a community. Yet, the laws create obstacles to

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1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

collaborative efforts. Intended to prevent anticompetitive behavior, the antitrust laws scrutinize joint conduct more closely than unilateral conduct. Therefore, activities health care providers could legitimately engage in independently may be subject to antitrust scrutiny if engaged in with others.

Some examples of beneficial arrangements help illustrate the barriers faced. Under current law, hospitals cannot agree to allocate services among themselves based on location or the type of services provided, even if the allocation is recognized as beneficial by consumers--including the business community, one of the largest purchasers of health care. Thus, two hospitals cannot agree that one will purchase an MRI and the other will purchase a lithotripter, instead of each purchasing both pieces of equipment. Such an agreement would be considered "market division," a violation of the antitrust laws.

Other examples of arrangements that risk antitrust liability include agreements to create health care "centers of excellence" and joint ventures to provide high technology services, even where such arrangements enhance the quality of care and eliminate the unnecessary duplication of services.

Even where the antitrust laws may not pose an actual threat, other factors create a "chilling effect" on health care providers' efforts to work together. Inadequate guidance from the federal government, the potential for treble damages and/or criminal prosecution, and the time and expense associated with challenges by enforcement agencies combine to inhibit hospital initiatives. In order to successfully cooperate and conserve costly resources, health care providers need to discuss and assess the needs of their communities. Yet, even these discussions may implicate the antitrust laws. A *Hospitals* magazine poll indicated that almost half of surveyed hospital CEOs agreed that antitrust concerns have slowed down or inhibited hospitals' collaborative efforts.

Given the lack of any clear direction on the federal level thus far, some states have passed laws to encourage collaboration on the part of health care providers. These laws are based on the doctrine of "state action immunity", a legal concept that exempts certain activities from federal antitrust prosecution if the state actively promotes and oversees them. To qualify for this state action immunity, the actions in question must be (1) pursuant to a "clearly articulated and affirmatively expressed state policy", and (2) "actively supervised" by the state.

These state laws, beginning with one adopted by the Maine legislature, typically provide that, pursuant to a clear legislative policy, hospitals and other health care

providers can apply for a "certificate of public advantage" from the state. If the application is approved, the state agency certifies that the benefits of the collaborative agreement outweigh the disadvantages. The state then continues to oversee the arrangement. In this way, both parts of the legal test are met.

Clearly, the ultimate solution to this problem lies at the federal level. There is now increasing evidence that federal policymakers intend to deal with antitrust issues. For example, the Department of Justice (DOJ) and the FTC have recently issued clarifying guidelines applicable to questionable health care activity. President Clinton's proposal contains some antitrust exemptions, and Senator Hatch has introduced legislation creating safe harbors for cooperative activities of providers. If appropriate federal policies can be developed, it would render legislation such as HB 2709 unnecessary.

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

March 15, 1994

To: Senate Public Health and Welfare Committee

From: Chip Wheelen, KMS Director of Public Affairs

Subject: House Bill 2709;
Cooperative Agreements Among Health Care Providers

The Kansas Medical Society supports the intent of HB2709 because it recognizes the need to allow health care providers to collaborate in an effort to provide cost-effective health care services. We would prefer, if possible, amendments to federal laws which would allow such collaboration but, short of that, we support the provisions of HB2709.

The current provisions of federal anti-trust laws are based on the premise that monopolistic or other anti-competitive activity is not in the best interests of the public. These laws assume that competition in the marketplace will provide consumer access to the lowest priced products and services, and that supply will meet or exceed demand. While this may be true under normal economic circumstances, there are occasions when the health care market does not reflect theoretical economic models. In some situations, cooperation may be more efficient than competition.

For physicians, relief from the constraints of federal anti-trust laws would allow meaningful discussions with insurance plans regarding credentialing issues, policies affecting care of patients, utilization review procedures, and payment issues. Under current proscriptions, we are reminded frequently by our attorneys to avoid discussions that might imply a collective effort to affect the health care marketplace.

We continue to lobby Congress through the American Medical Association for anti-trust relief. In the meantime, we respectfully request your favorable recommendation for passage of HB2709.

Thank you for considering our position on this matter.

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Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563
(913) 234-5564 Fax

March 15, 1994

To: Chairperson Praeger and Members, Senate Public Health Committee

From: Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine

Thank you for this opportunity to testify on H.B. 2709. We appear today in qualified support of this Bill.

There are trends underway in health care delivery that are positive, both for cost and availability of health care. Some of these will be facilitated by the ability of health care providers to enter into cooperative agreements that work to the advantage of both providers and consumers. To that extent, we support both the encouragement of "cooperative agreements" found in H.B. 2709, and also the detailed provisions for government oversight of such agreements.

In recent years, there have developed in Kansas and other states, a pattern of "arrangements" among providers, that offer opportunities for streamlined delivery, but also for abuse through size and arrangement. One of the most evident of these is the practice of hospitals to buy physicians' practices and weave them into a loose network of providers.

As a distinct minority physician group in Kansas, osteopathic physicians are always concerned about agreements among providers that may lead to the exclusion of certain providers in patterns of health care delivery and, ultimately, in the loss of physician choice by patients. We are, thus, concerned about some changes now occurring in Kansas, and about others that might occur should cooperative agreements, in the name of "health care reform", be initiated that are essentially anti-competitive in nature.

The many procedural safeguards that appear in this Bill, enhanced somewhat by amendments on the House side, appear to offer a means for the State, specifically the Department of Health and Environment, and an oversight committee, to observe and evaluate cooperative agreements among health care providers that might be proposed. We assume that high on the State's list of required characteristics of such agreements, would be efforts to protect and maintain a competitive environment that encourages provider access as well as protect patient choice of physician.

With these safeguards in the Bill, we support passage of 2709.

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3-15-94

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Robert C. Harder, *Secretary*

Testimony presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2740

The intent of HB2740 is to avoid duplication of state and federal regulatory requirements for some medical laboratories in Kansas.

At the present time, there are more than one thousand eight hundred clinical laboratories located in Kansas hospitals, clinics, commercial centers, and physician offices. Together, these laboratories receive several million patient specimens each year. The analytical test results reported by these laboratories represent an essential component of good health care delivery and disease surveillance in our state.

It is especially important that each clinical laboratory maintain uniform acceptable standards of operating proficiency and technical quality in order to assure that accurate test results are always produced. Kansas clinical laboratories are now evaluated against federal regulatory requirements outlined in the Clinical Laboratory Improvement Amendments of 1988 (CLIA'88 or 42 CFR Part 493). However, prior to the implementation of CLIA'88 in September of 1992, state requirements were established for some laboratory tests under KSA 65-1,107 and 1,108. Assuming that federal regulation of clinical laboratories will remain intact through the restructure associated with health care reform, Kansas requirements for laboratories performing HIV tests and syphilis serology tests can be eliminated as proposed in this bill. However, non-forensic urine screens for drugs of abuse are not currently included in federal regulatory requirements and thus should be retained under state legislation. These tests continue to be widely used for many applications which can include the employment and insurability of Kansas citizens. It is for these reasons that State regulatory oversight should be retained to assure the accuracy of urine drug screens.

The Kansas Department of Health and Environment supports the revisions proposed in HB2740.

Testimony presented by:

Dr. Robert C. Harder
Secretary
March 15, 1994

Senate P H & W
Attachment #5
3-15-94

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

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TO: ✓Senator Sandy Praeger, chair
Senate Public Health and Welfare Committee
Senator Audrey Langworthy
Senate Public Health and Welfare Committee
Emalene Correll, Research Associate

FROM: Mary Jane Stattelman, Assistant Attorney General
Phyllis Fast, Architect

DATE: March 14, 1994

RE: HB 3028

In regards to the questions raised on 4-14-94, regarding HB 3028 please be advised as follows:

1. The word "facility" is defined for both Title II entities (see page 35717) and Title III entities (see page 35594). Please note that both sections use the same language when defining what constitutes a facility.

2. Title III gives a laundry list of various entities that are deemed to be a place of public accommodation. (see page 35594) Please note that while the categories are an exhaustive list the examples within those lists are not an exhaustive list.

3. Page 3, section 6, line 43 should read " the standards established pursuant to this act."

4. The language on pages 8 and 9, section 12 regarding K.S.A. 79-32,175(a) should remain as is because the changes being proposed are so that the Kansas law reflects the ADA terminology. The purpose of these three statutes (K.S.A. 79-32,175 through 79-32,177) has been to give tax credits to Kansas citizens who alter equipment/work stations for specific individuals with disabilities (Title I, Employment) or who alter facilities for the general population for the individuals with disabilities (Title III, Public Accommodations and Commercial Facilities). Title II entities, state and local government services do not receive tax credits.

Senate PH&W
Attachment #6
3-15-94

As per your request, we have also enclosed a copy of the federal tax credit provisions. My apologies for not bringing the federal law along to the hearing so that this matter could have been accurately dealt with at that time. If you should have any other questions or comments please feel free to contact our office. Thank you for your assistance and interest in this matter.

from physical impairments, or other sexual behavior disorders;

(ii) Compulsive gambling, kleptomania, or pyromania; or

(iii) Psychoactive substance use disorders resulting from current illegal use of drugs.

Drug means a controlled substance, as defined in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812).

Facility means all or any portion of buildings, structures, sites, complexes, equipment, rolling stock or other conveyances, roads, walks, passageways, parking lots, or other real or personal property, including the site where the building, property, structure, or equipment is located.

Illegal use of drugs means the use of one or more drugs, the possession or distribution of which is unlawful under the Controlled Substances Act (21 U.S.C. 812). The term "illegal use of drugs" does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provisions of Federal law.

Individual with a disability means a person who has a disability. The term "individual with a disability" does not include an individual who is currently engaging in the illegal use of drugs, when the private entity acts on the basis of such use.

Place of public accommodation means a facility, operated by a private entity, whose operations affect commerce and fall within at least one of the following categories—

(1) An inn, hotel, motel, or other place of lodging, except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of the establishment as the residence of the proprietor;

(2) A restaurant, bar, or other establishment serving food or drink;

(3) A motion picture house, theater, concert hall, stadium, or other place of exhibition or entertainment;

(4) An auditorium, convention center, lecture hall, or other place of public gathering;

(5) A bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment;

(6) A laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment;

(7) A terminal, depot, or other station used for specified public transportation;

(8) A museum, library, gallery, or other place of public display or collection;

(9) A park, zoo, amusement park, or other place of recreation;

(10) A nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education;

(11) A day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and

(12) A gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation.

Private club means a private club or establishment exempted from coverage under title II of the Civil Rights Act of 1964 (42 U.S.C. 2000a(e)).

Private entity means a person or entity other than a public entity.

Public accommodation means a private entity that owns, leases (or leases to), or operates a place of public accommodation.

Public entity means—

(1) Any State or local government;

(2) Any department, agency, special purpose district, or other instrumentality of a State or States or local government; and

(3) The National Railroad Passenger Corporation, and any commuter authority (as defined in section 103(8) of the Rail Passenger Service Act). (45 U.S.C. 541)

Qualified interpreter means an interpreter who is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary.

Readily achievable means easily accomplishable and able to be carried out without much difficulty or expense. In determining whether an action is readily achievable factors to be considered include—

(1) The nature and cost of the action needed under this part;

(2) The overall financial resources of the site or sites involved in the action; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements that are necessary for safe operation, including crime prevention measures; or the impact otherwise of the action upon the operation of the site;

(3) The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity;

(4) If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; the number, type, and location of its facilities; and

(5) If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.

Religious entity means a religious organization, including a place of worship.

Service animal means any guide dog, signal dog, or other animal individually trained to do work or perform tasks for the benefit of an individual with a disability, including, but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.

Specified public transportation means transportation by bus, rail, or any other conveyance (other than by aircraft) that provides the general public with general or special service (including charter service) on a regular and continuing basis.

State means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the Trust Territory of the Pacific Islands, and the Commonwealth of the Northern Mariana Islands.

Undue burden means significant difficulty or expense. In determining whether an action would result in an undue burden, factors to be considered include—

(1) The nature and cost of the action needed under this part;

(2) The overall financial resources of the site or sites involved in the action; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements that are necessary for safe operation, including crime prevention measures; or the impact otherwise of the action upon the operation of the site;

(3) The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity;

(4) If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; the number, type, and location of its facilities; and

(5) If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.

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Stat. 327, 42 U.S.C. 12101–12213 and 47 U.S.C. 225 and 611).

Assistant Attorney General means the Assistant Attorney General, Civil Rights Division, United States Department of Justice.

Auxiliary aids and services includes—

(1) Qualified interpreters, notetakers, transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons (TDD's), videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments;

(2) Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments;

(3) Acquisition or modification of equipment or devices; and

(4) Other similar services and actions.

Complete complaint means a written statement that contains the complainant's name and address and describes the public entity's alleged discriminatory action in sufficient detail to inform the agency of the nature and date of the alleged violation of this part. It shall be signed by the complainant or by someone authorized to do so on his or her behalf. Complaints filed on behalf of classes or third parties shall describe or identify (by name, if possible) the alleged victims of discrimination.

Current illegal use of drugs means illegal use of drugs that occurred recently enough to justify a reasonable belief that a person's drug use is current or that continuing use is a real and ongoing problem.

Designated agency means the Federal agency designated under subpart G of this part to oversee compliance activities under this part for particular components of State and local governments.

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

(1)(i) The phrase *physical or mental impairment* means—

(A) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine;

(B) Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

(ii) The phrase *physical or mental impairment* includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

(iii) The phrase *physical or mental impairment* does not include homosexuality or bisexuality.

(2) The phrase *major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(3) The phrase *has a record of such an impairment* means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(4) The phrase *is regarded as having an impairment* means—

(i) Has a physical or mental impairment that does not substantially limit major life activities but that is treated by a public entity as constituting such a limitation;

(ii) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

(iii) Has none of the impairments defined in paragraph (1) of this definition but is treated by a public entity as having such an impairment.

(5) The term *disability* does not include—

(i) Transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;

(ii) Compulsive gambling, kleptomania, or pyromania; or

(iii) Psychoactive substance use disorders resulting from current illegal use of drugs.

Drug means a controlled substance, as defined in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812).

Facility means all or any portion of buildings, structures, sites, complexes, equipment, rolling stock or other conveyances, roads, walks, passageways, parking lots, or other real or personal property, including the site where the building, property, structure, or equipment is located.

Historic preservation programs means programs conducted by a public entity that have preservation of historic properties as a primary purpose.

Historic Properties means those properties that are listed or eligible for listing in the National Register of Historic Places or properties designated as historic under State or local law.

Illegal use of drugs means the use of one or more drugs, the possession or distribution of which is unlawful under the Controlled Substances Act (21 U.S.C. 812). The term *illegal use of drugs* does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provisions of Federal law.

Individual with a disability means a person who has a disability. The term *individual with a disability* does not include an individual who is currently engaging in the illegal use of drugs, when the public entity acts on the basis of such use.

Public entity means—

(1) Any State or local government;

(2) Any department, agency, special purpose district, or other instrumentality of a State or States or local government; and

(3) The National Railroad Passenger Corporation, and any commuter authority (as defined in section 103(8) of the Rail Passenger Service Act).

Qualified individual with a disability means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

Qualified interpreter means an interpreter who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary.

Section 504 means section 504 of the Rehabilitation Act of 1973 (Pub. L. 93–112, 87 Stat. 394 (29 U.S.C. 794)), as amended.

State means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the

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IV. Incentives and Resources

Disabled Access Credit

Eligible small businesses will be able to take a Federal tax credit of up to $5000 for certain expenditures made to bring their business into compliance with the Americans With Disabilities Act.

The tax credit is for small businesses which have gross receipts of less than $1 million a year for the preceding tax year, or have fewer than 30 full-time employees (those who work 30 hours a week for 20 or more weeks a year). The credit is for 50% of expenditures in excess of $250 and up to $10,250. Therefore the maximum credit in any one year is $5,000. The credit cannot be more than your tax liability for the year. Eligible expenses are those that enable a business to comply with applicable requirements of the Americans With Disabilities Act of 1990. Following is a list of eligible expenses:

- removing architectural, communication, physical, or transportation barriers which prevent a business from being accessible or usable by individuals with disabilities.
- providing qualified interpreters or other effective means of making aurally delivered material available to persons with hearing impairments.
- providing qualified readers, taped texts, and other effective methods of making visually delivered materials available to individuals with visual impairments.
- acquiring or modifying equipment or devices for individuals with disabilities.
- providing other similar services, modifications, materials or equipment.

This tax credit does not apply to new construction and eligible expenditures must meet standards set by the Secretary of the Treasury in consultation with the Architectural, Transportation and Barriers Compliance Board. To take advantage of the Disabled Access Credit, file form 8828, Disabled Access Credit. For more information, see the instructions for IRS Form 8826.

Federal Tax Deduction for Removal of Barriers

Businesses may choose to deduct expenses for making a facility or public transportation vehicle owned or leased for use in their trade or business, more accessible to and usable by those who are handicapped or elderly. The deduction is limited to $15,000.

this purpose, a facility is defined as all or any part of a building, structure, equipment road, walk, parking lot, or similar property. A public transportation vehicle is defined as a vehicle, such as a bus or railroad car, that provides transportation service to the public (including service for customers, if the business is not in the business of providing transportation services). Expenses that are incurred in building of completely renovating a facility or public transportation vehicle or in normally replacing depreciable property may not be deducted. In order for eligible expenses to be deducted, they must meet qualification standards as outlined in Internal Revenue Service Publication #907.

To deduct expenses for the removal of architectural and transportation barriers, the business must claim the deduction on its income tax return for the tax year in which the expenses were paid or incurred, and the deduction must be identified as a separate item. A partnership also may deduct these expenses on its partnership return for the first year for which the choice applies. For the choice to be valid, they must file the return for the tax year for which the choice is to apply and not later than the due date (including extensions) of the return. This choice applies to all such expenses, up to the limit, that were paid or incurred during the tax year. The choice is irrevocable after the due date of the return. A business must maintain adequate records to support the deduction.

Federal Jobs Credit

The jobs credit provides an incentive for business to hire persons from targeted groups that have a particularly high unemployment rate or other special employment needs. Employers can choose to take a jobs tax credit. The jobs credit is for qualified wages paid to members of targeted groups who work for the business.

A person is a member of a targeted group if the person meets the requirements of any of the following groups:

1. Vocational Rehabilitation Referral
2. Economically Disadvantaged Youth
3. Economically Disadvantaged Vietnam-Era Veterans
4. Supplemental Security Income (SSI) Recipients
5. General Assistance Recipients
6. Youths Participating in a Cooperative Education Program
7. Economically Disadvantaged Ex-Convicts
8. Eligible Work Incentive Employees
9. Qualified Summer Youth Employees

In order for a business to claim a jobs credit on wages paid to an employee, that employee must be certified as a member of a targeted group by the designated local agency. Designated agencies are local offices of the state employment security agency (Jobs Service). In the case of a student participating in a cooperative education program, the student is certified by the school administering the program.

The Jobs Credit must be claimed on IRS Form 5884, Jobs Credit. For more information on this credit see IRS instructions for Form 5884.

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