Testimony to the Kansas House Health and Human Services Committee
March 14, 2012

Dear Madam Chairperson and Committee Members:

Thank you for the opportunity to speak to you today about KanCare. My name is Dr. Ira Stamm. I am a psychologist in practice in Topeka who has been taking care of patients in Massachusetts and Kansas for forty-five years. I would like to share with you some information about health care insurance and to make one simple recommendation that will benefit all Kansans.

The Spanish philosopher Santayana once wrote the now familiar words, "Those who cannot remember the past are condemned to repeat it." Each of us carries in our wallet or purse an insurance card. If we have employer based insurance or an individual policy we are already enrolled in a managed care plan. At minimum this means that we can only see doctors in the plan's network, that many procedures and doctor visits need to be pre-authorized, that additional visits may require authorization, and at the end of treatment the insurance company can say the treatment was not "medically necessary" and decline payment.

This managed care model began to take hold in Kansas in the mid-nineteen eighties. KanCare incorporates many of these practices into its plan. Before Kansas transposes this private sector model to the public sector and writes checks for 2.8 billion dollars, it may be worthwhile for policymakers to look at the track record of managed care in Kansas over the past twenty-five years.

In 1972, a billboard near I-70 and the MacVicar exit in Topeka proudly proclaimed, "Welcome to Topeka, Psychiatric Capitol of the World." In the early 1990s the Menninger Clinic was in the process of deciding whether or not to enroll in managed care networks, and if so in which ones. From 1991-1995 I traveled to the headquarters of about one hundred managed care companies. Accompanied by one or two persons from the business and marketing side of Menninger, our group met with the CEOs and/or medical directors and network development executives from these companies.

Of the one hundred visits we made, two visits stand out in my mind. Sitting across the desk from the CEO of a national behavioral health company that covered more than a million individuals, the CEO calmly said to our group, "We will pay Menninger $400 for a day of treatment in the Menninger Hospital." The retail rate for a day of hospital care at that time was $1000. I did not know at that time Menninger's cost of providing a day of care but I was certain it was much more than $400 a day. During this conversation I thought to myself of the new business model for Menninger being suggested by this managed care company - based on an old joke from Vaudeville. "We will lose money on each sale but make it up in volume."

A second memorable visit unfolded in the following way. My colleagues and I were offered a tour of a different managed care company. We were ushered into a large room where 20-30 case managers were at work in their cubicles. At the front of the room was a white-board mounted near the ceiling. On the board were posted about a dozen names - after which was listed the following information: date admitted to the psychiatric hospital, name of the hospital, date of anticipated discharge, the patient's doctor's name, and the date the doctor was last contacted.

It was clear that patients admitted to a psychiatric hospital under a policy managed by this company were to undergo a high level of scrutiny and review. I knew then in the years 1991-1995

that Menninger and other psychiatric hospitals in Kansas and throughout America might not be able to survive the dual trends of lower reimbursement and abbreviated lengths of stay.

When the Center for Medicare and Medicaid agrees to pay or not pay for a given form of treatment, that decision is made by a panel of experts who have exhaustively reviewed all the scientific data about the illness and the best treatment practices for that illness. With mental health treatment it appears that the managed care companies simply decided they would no longer pay for inpatient care.

Today, patients with serious emotional problems who need extended inpatient care will spend 3-5 days in a local community hospital. These patients are then discharged into their communities where they may see a psychiatrist every 2-3 months for medication review and meet with a case manager or psychotherapist every two to four weeks. Anyone knowledgeable about mental health treatment will tell you that these are not comparable levels of care.

After struggling with the changes imposed by managed care for several decades, Menninger decided it could no longer survive economically in Topeka. On May 31, 2003 Menninger closed its doors in Topeka and moved to Houston, TX. Menninger no longer accepts insurance for most of its services.

During the past 10-15 years one other psychiatric hospital in Topeka closed its doors as have four others in the greater Kansas City area. The total number of psychiatric beds lost in Topeka and Kansas City during this era is about 550. In its best days Menninger employed 1100 staff in Topeka and another 200 staff in the greater Kansas City area. This included 200 psychiatrists, internists, neurologists, psychologists, social workers, and other health care professionals. The loss to the Kansas economy of these closures is estimated to be in the tens of millions of dollars. Most of the adverse changes to mental health treatment in Kansas followed the introduction of the managed care model in Kansas.

Before concluding, I would like to turn briefly from mental health to a different area of KanCare, namely, long-term nursing home care. Fewer than 5-10% of Kansans have long-term care insurance. Currently, Prudential, MetLife, and Unum Group have announced they will no longer offer long-term care policies. Most Kansans understand that if they need to enter a nursing home in their last years, they will first spend down their personal assets to pay for their care, and then rely on Medicaid to pay for the balance of that care. For me, personally, the notion that a for-profit, New York Stock Exchange listed company will oversee and make decisions about care in my final years is truly worrisome.

Recommendation: There is a simple alternative to the current proposed model of Kancare. I would recommend that KanCare incorporate itself as a not-for profit health care company. The prototype for this model currently exists with Kansas Health Solutions. Although Kansas Health Solutions has had some recent problems with embezzlement and theft, the model of Kansas creating its own non-profit company is a viable one. KanCare would then be wholly owned by the citizens of Kansas. Most services, including administrative services, would be provided by Kansans in Kansas. If additional skill sets are required by KanCare but are not available in Kansas, KanCare, like any business, could outsource those functions.

Thank you.

Ira Stamm, Ph.D., ABPP
3600 SW Burlingame Road - Suite 1A / Topeka, KS 66611/ 785 267-2440/ istamm@cox.net