M I N U T E S

COMMISSION ON HEALTH CARE COSTS

November 28, 1977
Room 519 - State House

Members Present

Frank Lowman, Chairman
Senator Arnold Berman
Representative Roy M. Ehrlich
John Erickson
Sister Caroline Jeunemann
Tom Lally
Representative Jamie Schwartz
Senator Wesley Sowers
Al Tikwart

Staff Present

Emalene Correll, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes Office
Bill Wolff, Kansas Legislative Research Department

Others Present

Ruth C. Dickinson, State Planning and Research, Topeka
Doug Johnson, Kansas Pharmaceutical Association, Topeka
Dick Hummel, Kansas Health Care Association, Topeka
Kathryn Klassen, Department of Social and Rehabilitation Services, Topeka
Rich Huncker, Insurance Department, Topeka
Sheryl Jacobs, Insurance Department, Lawrence
Petey Cerf, Kansans for the Improvement of Nursing Homes, Lawrence
Stu Entz, Kansas Association of Homes for the Aging, Topeka
Frank L. Gentry, Kansas Hospital Association, Topeka
Jack Roberts, Blue Cross-Blue Shield, Topeka
Jeff Wampler, Kansas Farm Bureau, Manhattan
Jack Milligan, Kansas Optometric Association, Topeka
Jerry Slaughter, Kansas Medical Society, Topeka

The meeting was called to order at 10:10 a.m. by the Chairman, Mr. Frank Lowman, who stated the agenda for the meeting was to discuss recommendations for action and for the Commission's preliminary report. He noted a number of issues and recommendations had been presented to the Commission, most of which the Commission had not been able to go into in depth. The secretary read a summary of the recommendations which had been presented to the Commission.

A Commission member reviewed the charge to the Commission and noted that health care is a rising cost for the state and federal governments and for everyone else -- individuals and third party payors. These costs can be divided into three components: (1) institutional providers; (2) individual providers; (3) peripheral services, i.e., pharmaceutical. He stated he felt the Commission had been reasonably satisfied with cost containment in the peripheral services and had not seriously looked into cost containment approaches relative to individual providers. However, he felt the Commission had heard sufficient testimony and had had sufficient discussion relative to institutional providers to determine if any action should be taken in this area. He noted there were three alternatives -- enlightened voluntarism, legislative action, reliance on third party payors -- and recommended the Commission determine what action it is going to take relative to institutional providers.

The importance of looking at specific recommendations to determine what can be reasonably implemented at this time that will have a positive effect on cost containment was noted. A Commission member noted that it is generally agreed that if one factor can be singled out in the long term as responsible for health, it is life style. He referred to a nationally funded program in Germany, supported by providers, that places emphasis on health maintenance and prevention. Placing such high recognition on good health places a stamp of approval on a healthful life style and creates public pressure for compliance. He suggested a resolution directed to the State Board of Education recommending the development of a curriculum which places emphasis on those practices which lead to good health. This would be a step toward meeting the need for development and proper implementation of life styles aimed at creating good health. After discussion, a motion was made and seconded for the Commission to support a concurrent resolution requesting the State Board of Education to develop ways to provide a continuing education program designed to improve the health and life style of Kansas citizens. In answer to a question, it was noted there is not much specific information about what is presently being taught in this area but general information indicates very little is taught. The person making the motion stated he hesitated to make the motion any more specific because of the lack of data at this time to substantiate specifics. He noted a resolution does not require the Board to do anything but it does point up the Commission's concerns. The motion carried.

None

A Commission member referred to Part II of the handout he had distributed (Attachment A). He suggested the Commission take a look at what the American Medical Association's dues are, the amount of money raised by the American Medical Association, and the amount of money the American Medical Association spent on the Presidential and Congressional elections and work for the redirection of some of this money for purposes such as implementing the motion just passed. He stated that a management team that would take a tough line, backed up by the Legislature, could turn the health care cost situation around. He also suggested the Commission focus on the recommendations made relative to the Title XIX program. It was pointed out that Attachment A included issues the Commission had not yet addressed.

A motion was made and seconded for the Commission to endorse the Brand Exchange Bill currently in the House Public Health and Welfare Committee. It was noted that Dr. Harder had indicated this bill would mean a one million dollar saving to the Department of Social and Rehabilitation Services in the first year. The Kansas Medical Society appears to be the only group opposed to the bill.

In answer to a question, a Commission member noted that physicians can presently prescribe generically. This bill reverses the present process by requiring the physician to indicate if he does not want the prescription to be filled generically. Some states which have passed similar legislation have found the savings to be nebulous. The million dollar saving is probably based on the assumption all prescriptions would be filled on a generic basis and there is no assurance this will happen. However, the bill does do two things -- it calls the physician's attention to the fact he can prescribe generically whenever possible and to the extent this is done there could be some saving. He stated the bill should be supported but the Commission should be realistic about its impact on cost containment. Motion carried.

Referring to Recommendation 16 (c), page 5, Attachment A, it was noted the Legislature had raised the tax on whiskey to offset the removal of the tax on drugs and prosthetic devices and to support alcoholism programs and research. A bill to increase the cigarette tax was defeated in part because of the prospective loss of revenue due to bootlegging across state lines. However, there is probably a level to which it could be raised and still not make bootlegging profitable.

A motion was made and seconded to hold health services provided under the state's Medical Assistance Program at the present level. It was clarified that the motion referred to the types of services provided, the total amount of money spent, and the percentile at which payment is made. It was noted this would be difficult for the Department of Social and Rehabilitation Services without cutting back on the spectrum of services presently offered or on those eligible for services. In principle this is a good concept but it is not practical unless the Department is given the tools to control the cost of services. There is no indication the rate of increase in health care provider costs will be less. Concern was expressed that this would affect only those under Title XIX. Any curtailment should be a curtailment for all.

It was pointed out that because federal funds are involved, the state must meet federal requirements relative to services offered and these may change. With the consent of the person making the motion and the second, the motion was amended to read "except those services mandated by federal law".

A Commission member commented he had heard that other states offer less services than Kansas and therefore welfare recipients are attracted to Kansas. Providing only those federally mandated services would help alleviate this. In answer to a question, staff stated that in addition to the mandated services, Kansas offers all but one service in which the federal government cost shares.

The motion failed. Senator Berman asked that the minutes reflect he voted no on this motion because he was concerned that approval of the motion could conceivably be used as an endorsement of curtailing state funds for therapeutic abortions.

A Commission member reviewed Part I of Attachment A, and noted a bill in the House relative to the provider crisis in Kansas. He stated the law of supply and demand will work and increasing the number of general practitioners will reduce costs. He discounted testimony that each additional physician will generate between $250,000 and $300,000 in additional health care costs each year in addition to his fees. A Commission member stated a bill by the Senate Ways and Means Committee (S.B. 447) would, in effect, make the University of Kansas School of Medicine a tuition free school for the training of primary care physicians and residencies in primary care. All new students would have to enroll in a state run plan which would require the physician to serve a prescribed amount of time depending on the area served in exchange for free tuition. Not serving this time would be considered a breach of contract with a fine of up to $25,000 per year for each year spent in the educational program. An interim Ways and Means Committee has proposed as an alternative, increment increases in tuition to $5,000 per year with a waiver of tuition for those serving a specified period in Kansas after completion of their medical education. The Senate Ways and Means Committee also recommended increasing the number of family practice residencies in the state but such legislation was not passed. This proposal was considered by an interim Ways and Means Committee but met with some opposition. A considerable amount was recommended for establishing additional out-reach residency programs in Kansas but the Council on Medical Education credentialing group turned the first proposed out-reach program down. He stated he felt enlightended voluntarism was a better approach than legislation for individual providers.

Another Commission member pointed out the proposed out-reach residency program was turned down because Garden City does not have adequate medical staff to provide the necessary education. He also noted that the concept the bill referred to is something the Commission has not looked at or had testimony on. The proponent of the proposal stated that organized medicine does not want this approach and is interfering with the development of out-reach programs. It was noted this approach has been used by the armed forces and they have a great shortage of physicians.

Referring to Attachment A, Part I, 2.c., a question was raised as to whether health care costs are less in the six counties that meet the physician-population criteria and if the recommendation was that all counties be brought up to this standard. The proponent stated this was not his intent. The statistic was to indicate Kansas is in bad shape. His recommendation is to leave it in the free enterprise system. It was noted the recommendations in Attachment A, Part I, do not seem to leave it in the free enterprise system.

A Commission member noted the deficiencies pointed out in Kansas and in the Florida study are statistical conclusions predicated on simply ratioing physicians to number of citizens in a given geographical area, usually a county. But service areas are not defined by county lines. It is true that in some counties, a person has to travel a greater distance than he would like to get medical services and this can be a problem in emergencies. However, based on usual criteria of health, i.e., live births, communicable disease rate, mortality rate, there is not a crisis in any Kansas county. These statistics are also predicated on the assumption that health needs are directly related to population and that the more physicians there are the better the health care is. However, there appears to be nothing to substantiate either of these assumptions. Also there is some evidence that increasing the number of physicians increases health costs. Using the lower figure of $250,000 in additional cost generated per additional physician quoted by Dr. Bill Roy and used in the Florida study, filling the immediate physician deficiency quoted in Part I, Attachment A, would increase costs approximately $340,000,000 in addition to fees paid to the physicians. Just taking primary care physicians, it would generate additional costs of approximately $150,000,000. This might create a substantial fiscal problem before the point at which competition takes over is reached.

It was noted that testimony indicated the physician shortage may very well be associated with the number of family practice residencies available in the state. A motion was made and seconded for the Commission to recommend that the Kansas University School of Medicine show a considerably greater interest in developing family practice residencies. By consent of the person making the motion and the second, the motion was amended to refer to residencies associated with providing primary health care. In answer to a question, it was clarified that the residencies referred to in the motion are those at Kansas University and the Wichita Branch. Motion carried.

A motion was made and seconded that the Commission urge the Legislature and the Board of Regents to support residencies in excess of the number of medical school graduates each year. Discussion of the motion was deferred until after lunch.

The meeting was recessed for lunch at 12:10 p.m. and was reconvened at 1:30 p.m.

The Commission member making the motion relating to additional residency positions noted that uncontested data seems to indicate that the highest natural retention of physicians is gained if medical school and residency within the state are combined. Presently, the Legislature funds only 140 residencies which means 30 percent of the state's medical graduates must go outside the state for a residency. If the additional residencies are not used, nothing is lost because no money would be spent. Reference was made to residents' statements that the stipends are too low and amending this motion to include a recommendation for increasing the stipend was suggested. It was noted that the Board of Regents, in its budget request, has recommended an increase in the stipend and medical malpractice insurance coverage for residents. Motion carried.

Requiring copay for all optional services was suggested. In answer to a question, staff stated federal regulations prohibit copay for mandated services. It was noted that optional services include dental services, chiropractors, physical therapists, optometrists, and intermediate nursing home services. Ms. Klassen, Department of Social and Rehabilitation Services, noted the recipient may be paying a portion of the intermediate nursing home care costs now. If this approach is adopted, strict rules would be needed relative to intermediate care. Otherwise people will be moved from intermediate care to skilled care which is a mandated service. She also noted the Department's new rules and regulations have limited services in some of the optional areas listed above. The Department has also attempted to limit optional services by limiting the number of days of care.

In answer to questions, Doug Johnson, Kansas Pharmaceutical Association, stated pharmacists have been able to collect the 50¢ copay on prescriptions on all but a very small percentage. There was a savings of approximately $1,300,000 the first year this requirement was in effect. Approximately $300,000 was probably due to a cut in over-utilization.

A Commission member, noting that requiring a $250.00 deductible on all insurance policies would save considerably more money, made a motion to limit expansion of services in the Medical Assistance Program and to require a deductible on all health insurance policies in the private sector. The motion died for lack of a second. A motion was made to recommend the adoption of the copay concept for optional services under Title XIX and to recommend that private contracts be required to offer only a $250 deductible. The motion was seconded for purposes of discussion.

In answer to questions, Jack Roberts, Blue Cross-Blue Shield, stated they have had a deductible policy available for about 12 years. Blue Cross-Blue Shield has also developed a shared pay plan in which the policy holder pays one-half of the first costs up to $500 or $1,000 of costs. Requiring a deductible or copay would probably affect utilization but it would also affect equity; would probably be better for elective services; would get the patient back into a financial relationship with the provider; and would probably make people more aware of costs, especially costs for elective services. However, it transfers costs more than it cuts costs. If the service is used, the cost is there and, if the person does not pay, that cost has to be spread to those who do pay. He also noted the deductible could have a reverse affect on costs, i.e., once the deductible limit is reached, a person might say "let's take care of all our problems before the end of the year."

Making the deductible on a per illness basis instead of per year was suggested. It was noted that the equities of different economic levels would probably be taken care of better under a copay approach. It was also noted that requiring that all third-party contracts be written with a $200 to $250 deductible would play havoc with negotiated fringe benefits which are an integral part of the labor-management system and already in place. Both labor and management would oppose the recommendation because the cost

of health insurance is tax deductible for the employer and the benefits are tax free for the exmployee. Staff noted that because some contracts are negotiated outside of the state, they would come under the rules of the Insurance Commissioner of the state in which they are negotiated. Therefore, contracts without the deductible could still be in effect in Kansas. This requirement could probably not be made retroactive.

A Commission member suggested requiring that all billings processed by an insurance company show what the cost would be based on 1970 figures plus the inflation factor so the consumer could see what is happening.

The second to the motion was withdrawn with the observation that there are some problems which the Commission cannot solve at this meeting in implementing this concept. By consensus, the Commission report is to note that the deductible approach would have some benefits but there are significant problems in implementing it. By consensus, the Secretary of Social and Rehabilitation Services is to be asked to do an analysis of the probable impact of copay or shared pay under the Medical Assistance Program for the Commission. The Department is to be asked to include any recommendations they wish to make relative to the implementation of this concept.

A motion was made and seconded for the Commission to recommend that the Department of Social and Rehabilitation Services introduce a prospective cost reimbursement system for institutional providers under the Title XIX programs. With the exception of nursing homes, these providers are now paid on a retrospective basis.

In answer to questions, Jack Roberts stated that in cooperation with the Kansas Hospital Association, Blue Cross-Blue Shield has initiated a voluntary prospective rate review program which is now mandatory for all contract renewals. By the end of 1979 every hospital with a Blue Cross-Blue Shield contract will be on a prospective reimbursement program. Discussion indicated that the rate established under this program would not necessarily apply to the 15 to 20 percent covered by other third-party payors or who pay for their own medical services. Mr. Gentry noted, however, that Medicare regulations state a hospital can have only one set of charges applicable to everyone and all Kansas hospitals participate in Medicare.

Answering a question, the member making the motion stated the system would be operated the same as it presently is for nursing homes. Ms. Klassen stated the Department of Social and Rehabilitation Services feels this is the approach which should be used and has started discussions with Health, Education and Welfare who would have to approve any plan for prospective reimbursement. A Commission member asked if this would increase paper work for hospitals or if the same report could be sent to Blue Cross-Blue Shield and the Department of Social and Rehabilitation Services. No direct answer was given, but Mr. Gentry stated the Department had been invited to sit in on all meetings relative to the Blue Cross-Blue Shield program and had attended some of them.

The motion carried.

A motion was made and seconded that the Commission recommend that relative to the establishment of prospective rates, the Department of Social and Rehabilitation Services be given the authority to prospectively review and approve budgets of institutional providers for the Title XIX program. In answer to a question, Ms. Klassen stated the term "institutional provider" includes hospitals, home health agencies, mental health centers and nursing homes. A question was raised as to how this could be implemented short of developing a Cost Containment Commission. It was noted that reports from states which have set up rate commissions indicate they are still struggling to correct mistakes and that not all commissions have had the impact that was anticipated. During discussion, some Commission members took exception to the implication that a "no" vote on the motion would mean that the person casting the "no" vote felt there was no problem with institutional costs. In answer to a question, the person making the motion stated this would mean an additional administrative cost to the provider for budget review. However, this would be an infinitesimally small fraction of the one hundred fifty-seven million disbursed by the state and it is necessary to keep this larger figure in mind. It was noted this matter needs to be addressed but there needs to be more time to look at the implications and for discussion before action is taken. Motion failed.

A motion was made and seconded to make a study of a rate review commission the top priority of the Commission for the next year. Motion carried.

A motion was made and seconded that the Commission recommend that the certificate-of-need statutes be amended to vest the authority for certificate-of-need review with the Secretary of the Department of Social and Rehabilitation Services. This would put the certificate-of-need program under the state agency with some responsibility for the payment of health care costs. It was noted this proposal had been discussed by the Health Systems Agencies, the Statewide Health Coordinating Council, the Department of Health and Environment and the Department of Social and Rehabilitation Services.

Indications from this discussion are that the Department of Social and Rehabilitation Services is neutral to this proposal. The other groups have supported leaving the review authority with the Statewide Health Coordinating Council where it now is and where the responsibility for health planning is located. The Department of Health and Environment may request legislation authorizing the SHCC to name a hearing officer to carry out review hearings. After further discussion, it was noted this apparently is an extremely controversial issue and therefore should not be voted on until further discussions have been held with the Department of Health and Environment and the Department of Social and Rehabilitation Services. Motion failed.

A motion was made and seconded that the Commission endorse the concept of home nursing and home health services. Motion carried.

Referring to the small amount of money allocated to the Commission, a motion was made and seconded for the Commission to recommend an increase of 5¢ per pack in the cigarette tax with the additional revenues raised by such tax to be used to underwrite the activities of the Commission, the testing of hypotheses of the Commission, and research relative to cigarette smoking. This would also help focus attention on life styles that create health costs. It was noted the state can probably afford to fund the Commission and it might be better to funnel the revenue into the educational program discussed earlier. It was also noted that the Legislature is reluctant to specify that monies raised from a specific tax be allocated to a specific program. The person making the motion stated he would agree to the monies going into the state general fund with the understanding it would go for health education, this Commission, and research. The motion failed.

A motion was made and seconded that the Commission recommend that all health care providers be placed under the certificate-of-need statutes. In discussion the following points were made: the threshold of the present statute is $150,000; capital expenditures, including equipment and facilities, would be included; because of the expense of setting up an office, this might put the state in the position of determining whether or not a provider could start a practice; physicians can do what a hospital cannot do without approval. The motion failed. It was noted this issue should be discussed further because the Commission has not looked at all the ramifications of the present system or of the change proposed by this motion.

A motion was made and seconded that the Commission recommend to the Legislature that a hospital rate commission with the authority to require financial disclosure, review budgets, set rates based on prospective rate review, and to conduct other reasonably related functions for all hospitals in Kansas, except state hospitals, be established legislatively. In answer to questions, the person making the motion stated the intent is not to present a bill that would detail the commission's membership, powers and duties, although he visualizes something similar to the Corporation Commission. The intent of the motion, purposely expressed in generalized terms, is to indicate to the Legislature that the Commission feels some type of permanently constituted body charged with some currently undefined powers and responsibilities would be desirable to control escalating costs.

It was noted that by earlier action the Commission had voted to give this concept top priority for future study; that hearings should be held before a final determination is made; and that this motion speaks to only one of the three components noted at the beginning of the meeting. The person making the motion stated this proposal would be a first step toward cost containment in one component of the problem and was recommended because of the availability of the experience of other states and the deliberations of Congress on this issue. The motion failed on a three to five vote.

In answer to a question, the Chairman stated the Commission will not meet again until after the 1978 Session of the Legislature. How active the Commission will be will depend on the Legislature's reaction to the Commission budget which has been submitted.

The following directions were given to staff for the Commission's interim report: The report is to follow the general format of interim committee reports with a background section on the problems the Commission was directed by the Legislature to address, a section indicating who appeared before the Commission; a summary of the testimony presented, and a section on conclusions and recommendations. Including a statement relative to the mood of the Commission at this time was suggested. Staff noted this would be difficult unless a specific statement was given to them to be included. One Commission member stated he would be filing a minority report relative to one part of the interim report. Staff asked that anyone wishing to file a minority report send such report to them so it could be included with the Commission's interim report. Emphasis was again given to the fact that this will be an interim report and that the Commission will be giving further attention to some of the items discussed today.

The meeting was adjourned.

Attachment B - Copy of the Kansas Hospital Association's response to the Department of Social and Rehabilitation Services' statement of the problem of rising health care costs presented to the Commission on July 1, 1977.

Prepared by Emalene Correll

Approved by Commission on:

June 14, 1978
(date)

EC/dmb

Attachment B

KANSAS HOSPITAL ASSOCIATION

MEMORANDUM

Frank L. Gentry
President

November 25, 1977

TO: The Kansas Commission on Health Care Costs
cc: Secretary, Dept. of Social and Rehabilitation Services

FROM: Frank L. Gentry

SUBJECT: OUR RESPONSE TO THE S.R.S. STATEMENT OF THE PROBLEM OF RISING HEALTH CARE COSTS OF JULY 1, 1977

At one of our appearances before your body, we asked for the privilege of responding to the S.R.S. statement.

As suggested in the introduction of the attached response, we do not think of this as a rebuttal, but instead, an expansion on some of the points raised in the S.R.S. paper.

The issues to which we have addressed ourselves are identified in the introduction.

Your review of this material will be appreciated. The Association welcomes any questions.

FLG:mkc

Attachment

1263 Topeka Ave. • Box 417 • Topeka, Ks. 66601 • 913/233-7436

Atch. B

RESPONSE OF THE KANSAS HOSPITAL ASSOCIATION
TO THE STATEMENT OF THE PROBLEM OF RISING HEALTH CARE COSTS
PREPARED BY THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES,
JULY 1, 1977

INTRODUCTION

In the preface to the Department of Social and Rehabilitation Services (SRS) Statement, the author thanks many members of the Department of Social and Rehabilitation Services for their patient efforts to explain the complicated aspects of the SRS Medical Program. The key word here is "complicated." Not only is the Medical Program that is managed by the State Department of Social and Rehabilitation Services a complicated program, but the medical care system with which this program interacts on a daily basis is a much larger, and even more complex, intricate system. There are numerous and quite diverse individual elements in the medical care system and the necessary interactions of these elements with each other, and with various public agencies, are important factors in determining the ultimate cost to the public for the purchase of medical care. Any analysis of health care costs must take this complexity of the medical care system into account.

The SRS Statement does an excellent job of identifying a majority of the most crucial issues being debated in the public arena today concerning the problem of rising health care costs. As noted earlier, each of these individual health issues, be it the subject of empty hospital beds or patient demand, is, of itself, quite complex. The Kansas Hospital Association (KHA) feels that on a number of these specific health issues the Department of Social and Rehabilitation Services Statement on Health Care Costs provides for an insufficient discussion of all aspects of the issue. KHA, therefore, has prepared this response which we do not view as a rebuttal of the SRS document, but in which we hope to take some of the major issues identified by SRS and present additional discussion for the consideration of the Commission on Health Care Costs.

The primary issues this response will address are: (1) the relationship between the medical care system itself and individual health status; (2) the role of demand for improved services in the question of rising health care costs; (3) historic role of community citizen input into the planning of health care facilities and resources; (4) the prospective rate review system that has been developed, cooperatively, by Kansas Blue Cross and Kansas hospitals; (5) the question of empty hospital beds and their costs to the citizens of the State of Kansas. In addition, included at the end of this response, the Kansas Hospital Association will provide some brief comments on other subjects that were discussed in the SRS report.

RELATIONSHIP BETWEEN THE MEDICAL CARE SYSTEM AND HEALTH

The SRS Statement has a section entitled, "Organization, Money and Public Health." In that section the author is of the opinion that our health care system is wasteful and inadequate; and that the delivery of health care is plagued by failures in organization, lack of planning, and poor coordination among its parts. The evidence to support these very broad, wild generalizations is that the United States now ranks seventeenth among nations in the world in infant mortality, and that many other countries have a longer life expectancy than does the U. S. The key factor to analyze is: "What is the true relationship between the organization and coordination of the medical care system and the life expectancy and other measures of health status?" In other words: "What does the organization of medical care system really have to do with individual health?"

Cotton Lindsay, in the introduction to the book, "New Directions in Public Health Care," which he edited, notes: "Health care has little to do with health ... about 10 percent by some estimates. The great recent increases in life expectancy have come largely from reducing infant mortality. If health care cannot greatly influence the nation's health, individual living habits can." Writing in that same book, Dr. Leon R. Kass states, " ... medicine itself, understood as a treatment of disease, may contribute

relatively little to our becoming and remaining healthy." Therefore, it would seem that we cannot so quickly blame our nation's standing in certain health statistics on the structure of the medical care system.

If not there, then what factors are there that might tend to explain some of these health statistics? One potential answer to this question is the lifestyle we Americans lead today. As the SRS Statement noted, most deaths in the age range from 10 to 70 result from either degenerative disease or from accidents, suicide or homicide ... and these diseases do not lend themselves readily to medical intervention. Many factors which could reduce the incidence of death from these diseases have very little to do with medicine, but a great deal to do with the changes in the way we live.

In his essay mentioned previously, Dr. Kass notes, "I, myself, would guess that well more than half of the visits to doctors are occasioned by deviations from health for which the patient, or his way of life, is in some important way responsible." Dr. Kass feels that most chronic lung diseases, much cardiovascular disease, most cirrhosis of the liver, many gastrointestinal disorders (from indigestion to ulcers), numerous muscular and skeletal complaints (from low back pain to flat feet), venereal disease, nutritional deficiencies, obesity and its consequences, and certain kinds of renal and skin infections are an important measure - self-induced or self-caused - and contributed to by smoking, overeating, overdrinking, eating the wrong foods, inadequate rest and exercise, and poor hygience. To these conditions must be added the result of trauma, including automobile accidents in which drunkeness plays a leading part, and suicide attempts, as well as accidental poisoning, drug abuse and many burns. Thus it appears that the way we live has much to do with the way in which, and when, we die. The medical care system cannot be expected to rescue our society from what appears to be an epidemic of individuals living self-destructive lifestyles.

THE ROLE OF DEMAND

The SRS Statement asks us to belive that the chief cause of the rapid escalation in hospital costs since 1950 has been the rise of the third party payor in the form of government and private insurance. There has been an increase in the percentage of people covered by third party arrangements, and this fact no doubt has had an impact on costs. The issue of what has been the chief cause of the rate of increase in hospital costs needs a more detailed analysis, as the answer is more fundamental than merely the suggestion that the responsibility lies with the changing of a prepayment mechanism.

Martin S. Feldstein, in his book, "The Rising Cost of Hospital Care," finds that increasing demand for hospital services has been identified as the primary reason for the rate of cost increases for hospitals. He attributes this to the fact that both rising income and more comprehensive health insurance coverage, both private and public, has increased the willingness of individual patients to pay for more and better hospital care. The result has been a small rise in per capita patient days and a substantial increase in the cost per day of hospital care. Higher demand has induced a change in the technology of hospital care to a better but more expensive product. Feldstein goes on to say that the changing character of the hospital product implies that cost increases should not be interpreted as evidence of inefficiency or a low rate of technological process. The role of private insurance in encouraging additional demand for health services must, of course, be recognized.

COMMUNITY INVOLVEMENT IN HEALTH PLANNING

Health planning is not new in Kansas. In the early 1960's, a voluntary health planning effort was undertaken with joint sponsorship of Kansas Blue Cross and Blue Shield, the Kansas Hospital Association, the Kansas Medical Society, the old Department of Social Welfare and the Department of Health. The purpose of this program was to encourage more formal and enlightened health planning by Kansas hospitals. The program served to

successfully educate and influence hospitals to plan facilities based on determinations of community need. This program was known as the Kansas Health Facilities and Information Service (KHFIS). It was entirely a cooperative, voluntary effort by many different health professionals.

This voluntary planning effort existed in Kansas until 1966 when the federal government passed the Comprehensive Health Planning Act. This Act divided the State of Kansas into health planning regions. In each region, all projects to add services, to expand facilities and to make major equipment purchases were reviewed by a local planning council. In 1972, the Kansas Legislature accepted the recommendations of the Kansas Hospital Association and enacted the state's first Certificate of Need law. This law required that before a facility could acquire or maintain a license to operate, all new construction and expansions above a specified dollar level must have received the approval of the comprehensive health planning agency. These local CHP agencies were, to a great degree, composed of local citizens. Although health care professionals served on the agencies, there was a broad base of private citizen input. The role and function of the Comprehensive Health Planning Council, as with its successor, the Health Systems Agencies which were created by the passage of the National Health Planning and Resources Act (P.L. 93-641), has been to determine the need, in light of community health care objectives, for a particular construction or service expansion project.

In addition to the local health planning efforts above described, the Hill-Burton program also helped ensure that hospital construction was directed towards meeting community health needs. In order for a hospital to receive Hill-Burton funds, each building project was reviewed by the State Hill-Burton Agency as to whether or not it was consistent with the State Hill-Burton Plan. During much of the life of the program the State Hill-Burton plan was developed and priorities established, based upon information provided by KHFIS, and later by KHA.

to state, or even imply, that any hospital construction or expansion has taken pla- on the part of hospitals without community input is not taking into account the history of health planning in the State of Kansas.

PROSPECTIVE REIMBURSEMENT

A prospective reimbursement system is mentioned in the SRS report as one of the proposals that should be considered as part of an effort to attempt to control the increase in hospital costs. In 1969, only two states had prospective reimbursement programs. One of these, in Indiana, was voluntary and one was conducted by a state government. By May, 1977, there were 32 state or sub-state programs. These 32 programs, in effect, were determining the hospital charges for more than one-fourth of the nation's hospitals, in part or all of 28 states. Five of these programs were established during 1976.

The Kansas Hospital Association, during 1977, went on record publicly stating that the Association feels that prospective rate and budget review is the most effective long-range reimbursement reform available in our hospital system. During the summer of 1977, the KHA Board asked that Blue Cross mandate that its rate review system become the only Blue Cross contract available to Kansas hospitals. On August 11, 1977, the Blue Cross Board of Directors concurred with the Kansas Hospital Association Board, and that decision was made. Therefore, all Kansas hospitals that will be participating as Blue Cross member hospitals will be under the existing prospective rate review program by the end of 1979.

The program developed here in Kansas is one in which each hospital determines its financial needs for the upcoming budget year, and submits a comprehensive revenue and expense budget to the Kansas Hospital Rate Review Committee. This Rate Review Committee is composed entirely of consumers. The Rate Review Committee members are selected from the subscriber membership of the Blue Cross Board of Directors, former subscribers of the Board, and Blue Cross subscribers at large. This body has full authority to approve, reduce or reject the rates proposed by an individual hospital.

ke most of the other policy and reimbursement questions affecting the health care system, the development of the Kansas Prospective Pate Review Program was a complex and involved process. Kansas Blue Cross and the Kansas Hospital Association, working cooperatively, began development of the prospective rate review program in 1970. After seven years of study, the participants are still finding that flexibility is needed in the system so that not only the needs of health care consumers can continue to be met as times change, but also so that the financial needs of the hospitals will also be addressed in a realistic manner.

The system developed in Kansas was modeled after the highly successful Indiana program mentioned earlier. The program here is an effort to reach a balance between the legitimate financial needs of Kansas hospitals, financial needs that must be met in order for hospitals to continue to provide services to their differing constituencies, and the needs of the general public to insure that the cost of a hospital's operation upon which rates are based are, in fact, reasonable and have been reviewed by an impartial consumer body.

It is the opinion of the Kansas Hospital Association that the prospective rate review program embarked upon by Blue Cross, in cooperation with hospitals, will have achieved visible success within the next year by restraining, to the degree that any reimbursement system can, the rate of increase in health care costs.

It should be noted that most of the prospective rate review systems working today must still be considered to be in an experimental stage. The systems often are based on different reimbursement models, using different assumptions, and approach the problem of determining the adequacy of rates in vastly different ways. No one system has yet demonstrated that it has developed the best methodology and review process. The Kansas Hospital Association therefore, while continuing to encourage the participation of our hospitals in the prospective rate review program conducted by Blue Cross, recognizes

.at changes may become necessary in this program in order to insure that the legitimate interests of both the consuming public and hospitals are being protected.

EMPTY BEDS

On the subject of empty acute care hospital beds in Kansas, there has been a great deal of recent discussion of the exact number, if any, of excess beds, or how to calculate the cost of maintaining these beds. There is no doubt that on any given day in the State of Kansas there are approximately 4,200 empty hospital beds. An analysis of whether or not these beds represent excess hospital capacity must be carefully conducted. The first and foremost point to take into account is that although there may be 4,200 empty beds on any given day, the 4,200 beds that are empty vary significantly from day to day. It is to be expected that in the hospital industry, like any other industry, there must be something less than 100 percent capacity utilization.

As the Statement by the Department of Social and Rehabilitation Services notes, the Department of Health, Education and Welfare has recommended the establishment of national guidelines for health planning. These guidelines were published in the September 23, 1977 Federal Register. They are an attempt on the part of the Department of Health, Education and Welfare to establish standards for hospital occupancy rates and for the ratio of hospital beds per thousand population. One such guideline that has been proposed is that there should be an annual average occupancy rate of at least 80 percent in short-term general hospitals. The Department goes on to make exceptions to this requirement, and notes that: "Lower average annual occupancy rates are often required by small hospitals to maintain empty beds to accommodate normal fluctuations of admissions. In rural areas where there are significant numbers of small (fewer than 4,000 admissions per year) hospitals, an average annual occupancy rate of less than 80 percent may be justified."

...ly 25 Kansas hospitals have more than 4,000 admissions per year. To further illustrate this point, there is attached a chart that shows the occupancy rate for various bed size Kansas hospitals. The combined occupancy rate for the 11 large hospitals that have more than 200 beds exceeds the 80 percent optimal criteria. These hospitals account for 46 percent of the total number of inpatient days in Kansas. From 200 beds on down, the percent of occupancy decreases as the size of the hospital decreases. This results because the smaller the institution, the more available capacity that is necessary to handle normal fluctuations in the volume of service, and also to provide sufficient capacity to enable the institution to handle a serious catastrophe, such as a multi-vehicle accident.

The Kansas Hospital Association feels that we should again emphasize that occupancy rates are not, and should not be interpreted as, an efficiency ratio. To state that hospitals of less than 100 beds do not operate efficiently and offer as evidence of that assertion occupancy figures, reveals a total lack of understanding of the practice of hospital administration.

The Kansas Hospital Association, in its response to the proposed National Health Planning Guidelines, addressed this question by stating:

> "The assumption that the hospitals with low occupancy rates are inefficient is incorrect. These hospitals staff their facilities for the minimum occupancy and arrange their services accordingly. It is, therefore, entirely possible to operate in a cost-effective manner at a much lower occupancy rate than the guidelines anticipate."

A corollary question to the subject of empty beds is: Why are additional hospital beds being constructed? This is to be expected because our state population has not been static. In recent years, people have moved from the rural areas of Kansas to the larger communities. This has necessitated the need for additional hospital construction in these cities.

L-BURTON CHARITY CARE

The Statement on Health Care Costs prepared by the Department of Social and Rehabilitation Services discusses the charity care obligations of those Kansas hospitals who received Hill-Burton funds. Since this issue has been fully debated before the Commission on Health Care Costs, we will not go into much detail in this response. The Kansas Hospital Association does feel compelled to reiterate that during its recent testimony before the Commission, the State Department of Health and Environment reported that all Kansas hospitals are fully meeting their charity care obligations.

CONCLUSION

The Kansas Hospital Association recognizes the severity of the problems of rising health care costs. The Association and its member hospitals are committed to a wide range of cost containment programs. The Kansas Hospital Association's goal with this response is therefore not to deny the existence of the problem, but is to provide the Commission with a different perspective on some of the major issues identified in the Statement on Health Care Costs prepared by the Department of Social & Rehabilitation Services.

November 23, 1977

ANALYSIS BY BED SIZE OF KANSAS HOSPITALS

1976

Bed Size	Number of Hospitals	Number of Beds	Number of Admissions	Number of Inpatient Days	Percent Occupancy
6-24	25	473	12,455	73,172	42.5
25-49	39	1,343	38,326	275,089	55.8
50-99	46	3,273	95,005	746,315	62.4
100-199	23	3,209	99,271	816,994	69.6
200-299	4	899	38,219	274,826	83.5
300-399	3	1,101	42,557	328,076	81.4
400-499	0	0	0	0	0
500 or more	4	2,592	102,703	778,238	82.0