Approved March 3, 1983
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers at
Chairperson

Noon ~~a.m./p.m.~~ on February 28, 1983 in room 526-S of the Capitol.

All members were present except:

Senator Francisco, and Senator Roitz, excused

Committee staff present:

Norman Furse and Bill Wolff

Conferees appearing before the committee:

Bob W. Storey, Kansas Hospitals for the Voluntary Effort
Donald Wilson, President, Kansas Hospital Association
Wayne Johnston, President, Blue Cross-Blue Shield
Jerry Slaughter, Kansas Medical Society
Dr. Lois Scibetta, Kansas State Board of Nursing
Dick Hummel, Kansas Health Care Association
Kenneth Schafermeyer, Kansas Pharmacists Association
Audrey Kennedy, Health Systems Agency of Northeast Kansas
Harold E. Riehm, Kansas Association of Osteopathic Medicine

Others present: see attached list

SB 87 - Hospital cost containment act
SB 285 - Creating a state health care commission

Bob W. Storey, Kansas Hospitals for the Voluntary Effort, testified in opposition to SB 87, and distributed testimony stating that the cost of setting up a commission would be astronomical, with no assurance of any decrease in health care costs; all hospitals which he represents have a detailed accounting of all receipts and expenditures which are available to state and legislative committees; to have to submit to a commission which is not even aware of the internal operations of the hospital would be disastrous; and though interest in rising health care costs is great, that concern is not great enough to dictate that SB 87 be implemented into law. This could result in a deteriorating health care service for patients, or in closing down some of the health care facilities in the state. (Attachment #1).

Mr. Storey testified in opposition to SB 285, and distributed testimony stating that there have been numerous health care studies in the state over the past years, and the most progress that has been made in holding the line on health care costs has come from the hospitals themselves. The studying of increasing health care costs is a constant and on-going program with the hospitals he represents, and is a matter which should be left to the professionals in the field and not done by legislative act. A health care commission, created by the passage of SB 285, would not be any more efficient than the Board of Directors at each individual hospital. (Attachment #2).

Donald Wilson, President, Kansas Hospital Association, testified in opposition to SB 285, and distributed testimony stating that they see no major difference between the responsibilities of the existing SHCC and the six study topics set forth in this bill, and feel that a State Health Care Commission would be costly and duplicative of the SHCC. Mr. Wilson said the concept has merit and should be explored, but questioned whether this legislation is necessary. He suggested a steering committee be established to research the best way for a commission to be set up; make a recommendation to the Governor's office; and allow the Governor to establish a commission. (Attachment #3).

Mr. Wilson testified in opposition to SB 87, and distributed testimony stating that there are a number of current efforts being undertaken by major payers of health care in Kansas, such as Medicare, Medicaid, and Blue Cross. These three payers represent almost 80% of the payments to Kansas hospitals for services provided, and since 80% of the payments for hospitals in Kansas already are subject to some form of rate setting, the establishment of a commission is redundant. Establishing a commission as proposed by the legislation will force hospitals to maintain at least two complete separate sets of records in order to accommodate both the commission and the other third party payers. In summary, KHA opposes this bill because each of these payers is already developing new prospective payment systems that will establish payment rates for Kansas hospitals; a similar effort was attempted in Colorado and was a complete failure because it created an expensive, burdensome, and bureaucratic nightmare; and the cost of establishing such a commission will be great, both to the state and the Kansas hospitals. (Attachment #4).

Wayne Johnston, President, Blue Cross-Blue Shield, testified in opposition to SB 87, and said that they have been involved in hospital rate review for the past several years, and it served a purpose, but its usefulness is past. There is a wide variation in charges made by health providers for the same services. They are developing a preferred provider program, and he believes it has a much greater potential to restrain the cost of health care. Mr. Johnston declared that the preferred provider concept does not refer to just hospitals. It is designed to establish a limit as to what we will pay each of the providers for medical services provided, and it introduces price competition into the medical community. He said that it does appear that prospective rate review was a viable cost containment of the past, but there are other ways that are more effective. He feels that SB 285 is appropriate and heartily endorses the bill.

Jerry Slaughter, Kansas Medical Society, testified that SB 285 is a concept they do not oppose, but they do have some concerns because there is no legislator on the commission, and the general charge to the commission is vague and does not relate directly to hospital health care. He suggested that that section be rewritten. He stated that KMS opposes SB 87.

Dr. Lois Scibetta, Kansas State Board of Nursing, testified in support of SB 285, in general, but suggested that a representative of the nurses association be included on the board. She said that she would submit written testimony on SB 87 later.

Dick Hummel, Kansas Health Care Association, testified in support of SB 285, with the inclusion of a nursing representative on the commission.

Kenneth Schafermeyer, Kansas Pharmacists Association, testified in support of SB 285, with the proposed amendment that "Item 5, beginning on Line 33 of the bill, should be deleted, and No. 6 should be renumbered as No. 5". (Attachment #5).

Audrey Kennedy, Health Systems Agency of Northeast Kansas, testified in support of SB 87, with line 151-152, Section 6 (a) amended to read "from the date that the Commission is fully staffed or operational", and Line 99, Section 5 (b) amended to read "The Advisory Committee shall be the SHCC". (Attachment #6).

Ms. Kennedy testified in support of an amended SB 285, which would assign the health care cost study and the authority to collect uniform data to conduct the study to SHCC. HSANEK believes that the SHCC could serve the function of the proposed committee. (Attachment #6).

Harold E. Riehm, Executive Director, Kansas Association of Osteopathic Medicine, testified in opposition to SB 87, and in support of SB 285. He would like the representation on the commission to be designated as one "licensed by the Board of Healing Arts" - not as a "member of the Kansas Medical Society".

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at Noon ~~a.m./p.m.~~ on February 28, 1983

Written testimony in opposition to SB 87, from Paul E. Fleener, Director, Public Affairs Division, Kansas Farm Bureau, was distributed to the committee.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-25-83 - noon

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Jack Roberts	BC-BS
Marlow Dalinger	BC-BS
Wayne Johnston	BC-BS
Donald A. Wilson	Ks Hosp. Assoc.
Ron Schmidt	KDH&E
Robert Goolsbee MD	Freestanding Amb Surg Center
Howard M. Chase	Stormont Vail Med Center
Jeffrey Schilling	Stormont Vail Reg. Med. Center
Ken Schafermeyer	KS Pharmacists Assoc.
Lynelle King	Ks State Nurses Assn
Jimmie Norsworthy	BC-BS
Audrey Kennedy	HSANEK
Guillermo Barreto-Vega	HSANEK
Gary Petz	KDOA.
Ron Todd	Ins Dept
Bob Storey	KHVE
Dick Hummel	Ks Health Care Assn
Dr Lois R. Scibetta	KSBN
George B. Welch	D of A
[illegible]	KRLDA
Joseph H. Cassell	—

2-28-83

#1

TESTIMONY REGARDING SENATE BILL 87
BEFORE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
BY BOB W. STOREY
REPRESENTING KANSAS HOSPITALS FOR THE VOLUNTARY EFFORT

MEMBERS OF THE COMMITTEE:

Again I represent the Kansas Hospitals for the Voluntary Effort. The association which I represent appears here today to strongly oppose the provisions contained in Senate Bill 87.

As is contained in Senate Bill 285, Senate Bill 87 sets up a commission and advisory committee to study and report on hospital costs. However, it does go far beyond the provisions contained in Senate Bill 285. This bill provides, among other things, that the chairman of the commission would receive an annual salary in an amount equal to the annual salary prescribed by law for a Judge of the Court of Appeals; and that the other members of the committee should receive an annual salary in an amount equal to that paid to a state District Judge. In addition, all travel expenses which are considered actual and necessary would be paid by the State of Kansas. Besides these employees, there would be an Executive Director and a Deputy Director and Secretary, who would be unclassified and again paid by the taxpayers of the State of Kansas. As if these were not enough employees, the bill also makes provision for the commission to employ such other full-time staff or part-time

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as it deems necessary to implement and carry out its duties.

All the provisions which are discussed above are contained in Sections 2, 3, and 4, which speak to the Kansas hospital commission. As this legislative committee can readily see, the costs would be astronomical at this point, with absolutely no assurance that any decrease in health-care costs would result from this large expenditure imposed upon the citizens of the state of Kansas.

Section 5 on page 3 of Senate Bill 87 makes provision for the advisory committee on hospital costs. I would like to point out here that under Section (e) on page 4, at least the costs in this section would be lower, since the committee members would be paid subsistence allowances, mileage, and other expenses as provided in subsection (e) of K.S.A. 75-3223 and amendments thereto.

Again, if the committee will take notice of the provisions contained in Sections 6 and 7, these provide briefly that the commission shall establish rules and regulations of a uniform nature under which hospitals shall record their revenues and expenditures for given periods of time. I would submit to the legislative committee that these records already are available and are already being prepared by hospitals. All of the hospitals that I represent have a detailed full accounting of all receipts and expenditures, which have been made available in the past for the scrutiny of state and legislative committees which have requested the same. In Section 7 it also provides

that the commission receive a proposed budget from each hospital in its next fiscal year. I can only say to the committee that all of the hospitals which I represent not only submit a proposed budget each year to the staff and to the Board of Directors, but that budget is scrutinized closely by the professional Board of Directors and has to be approved by that entity before it may be implemented.

Section 8 provides that if the commission determines a budget submitted by a hospital is unreasonable, it then has to submit in not less than 45 days prior to the proposed adoption date a notice of unreasonableness to the hospital. Then a public hearing on such budget shall be held not less than 30 days prior to the proposed adoption date for the budget, and the hospital has to present evidence on which the commission may either approve or disapprove the budget. I submit to the committee that this is completely handcuffing the hospitals in their operations, since they have to go through all of the procedure which is detailed above, after they have had professionals determine what their budgets should be and have had professionals adopt or reject such budgets in the form of Boards of Directors meetings. To have to submit themselves to a commission which is not even aware of the internal operations of the hospital and let that commission decide whether it may or may not make expenditures or receive receipts would be total disaster to that hospital being able to maintain a constant health-care maintenance program which would be to the benefit of its patients.

In Section 9 it states that the commission shall establish, by rules and regulations, types and classes of changes in hospital rates and charges, other than changes provided for in a budget adopted in accordance with section 8, which are subject to review and approval of the commission. The bill goes further to say: "Not less than 30 days prior to a change in rates or charges which is subject to this section, the hospital has to submit to the commission ... an application for such change ..." which is reviewed by the commission and it later is determined reasonable or unreasonable. Again, if the commission determined that the rate increases are unreasonable, the same provision would apply that we would have to go to another public hearing, which encompasses some 80 days, including the 30 days' notice 40 days after submission of the charge, and 10 days' notice of the time and place of hearing. Again I submit to the committee that this is cumbersome and ineffective, and rather than curb costs this type of activity would do nothing but increase costs both to the taxpayers and the patients of the hospitals.

The rest of the bill goes on to state that the commission shall not permit the hospitals to charge unreasonable rates, unnecessary expenditures, etc., without the approval of the commission, and the commission has full power to order at any time that the hospitals may not charge certain rates for its services.

The bill then goes on in Section 13 to state what powers the commission has, which again is to undertake certain studies, etc.

Now under Section 17 the bill provides that: "Violation of any provision of this act or any rules and regulations adopted hereunder is a class C misdemeanor." I would like to point out to the committee here how very grave and serious this particular section would be if Senate Bill 87 were implemented. Section 17 says that if the commission adopts rules and regulations, which it may do at its discretion without approval from any other entity, and that if these rules and regulations are violated by any of the hospitals, then that hospital has committed a criminal act.

I would like to point out to the committee the seriousness of this legislation in giving a study commission of this type the power to adopt rules and regulations not subject to anyone's review or control and to provide criminal sanctions for any party violating the same. This gives carte blanche authority to the commission to by law regulate what a hospital may or may not do, when in fact the commission has no knowledge of the internal operations of a health-care facility such as a hospital. If one of these hospitals inadvertently violated any of these rules and regulations, then it could be found guilty of a criminal action.

I submit to this committee that even though the interest in rising health costs is great among all citizens, taxpayers, and patients paying for health provider insurance policies in our state, that concern is not great enough to dictate that Senate Bill 87 be implemented into law. This is a dangerous precedent which could and would result in deteriorating

health care services for patients, or most likely in closing down of some of the health care facilities in our state.

Again, madam chairperson and members of the committee, the KHVE association asks that Senate Bill 87 be reported unfavorably, which would be in the best interests of all health care recipients in the state of Kansas.

Respectfully submitted,

BOB W. STOREY

2-28-83

#2

TESTIMONY REGARDING SENATE BILL 285
BEFORE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
BY BOB W. STOREY
REPRESENTING KANSAS HOSPITALS FOR THE VOLUNTARY EFFORT

MEMBERS OF THE COMMITTEE:

On behalf of KHVE, I first would like to express to the committee our concern over rising health-care costs in the state of Kansas. I know this committee is vitally interested in the topic on behalf of those taxpayers in our state who are subjected to paying these costs.

However, I would like to point out to the committee that the KHVE would not be supportive of Senate Bill 285, for various and sundry reasons which I wish to express in this testimony.

First, there have been numerous health-care studies in the state of Kansas over the past years. Various committees have been formed to try to determine the cause of rising health-care costs and how to curb the increase in these costs in an efficient manner. There have been no solutions by any of these study groups which have resulted in the lowering of health-care costs. As a matter of fact, the most progress which has been made in holding the line on health-care costs, or attempting to implement programs which would result in the least possible increase, has come from the hospitals themselves.

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In case the committee is not aware, the studying of increasing health-care costs is a constant and on-going program with the hospitals which I represent, and will be a part of the regular program so long as the hospitals remain in operation.

There is an attempt by Senate Bill 285 to create an independent state health care commission to study all of the items set out in Section 1 of the legislation. I would submit to this committee that these items--the medical necessity of health care services rendered to citizens of this state, the quality, the reasonableness of the charges, etc.--are topics of discussion at almost all of the hospital board meetings, the regular meetings, and topics of concern throughout the day-to-day operation of each hospital by its medical and administrative staff.

In attempting to set up this commission, I believe the committee should know that there already is in effect a blue ribbon health care commission for each of the hospitals in the association which I represent, in the form of the Board of Directors. For example, the larger hospitals in the group which I represent, such as the Wesley Medical Center in Wichita, St. Joseph's Hospital in Wichita, Stormont Vail and St. Francis in Topeka, and the Johnson County Medical Facility in Johnson County, all have very active professional men and women on their Boards of Directors. These are persons such as bankers, lawyers, doctors, investment counselors, certified public accountants, and many other qualified individuals. It is the job of these persons as members of Boards of Directors to study all of the aspects

involved in health-care costs, which of course would include the quality, efficiency, rising costs, and all other related matters.

In light of this, it is hard to understand why a health care commission, which would be created by the passage of Senate Bill 285, would be any more efficient in looking into these problems than those independent Boards of Directors at each individual hospital.

Also, Senate Bill in Section 1, subsection (e), provides that the commission "shall employ a staff, and may, irrespective of the provisions of K.S.A. 75-3738 to 75-3744, inclusive, and amendments thereto, enter into contracts with individuals or firms to perform any and all duties prescribed by the commission incident to carrying out the requirements of this act." This would appear to KHVE to set up a system wherein it would be very costly to the taxpayers of this state, if in fact consulting groups, individuals, and professional associations were hired to do certain cost analysis and to come up with findings and recommendations. We again see that this could be one of the major factors in increasing health-care costs. I am sure this matter has been studied for such a long period of time that the findings and recommendations of the health-care commission are going to be no different than those which have been reported in the past. That is simply the fact that due to rising costs and technology it is almost if not impossible to maintain a constant level of health-care costs with all of the innovations which are being introduced today into our society.

In Section 2 it provides that the commission shall make an annual report to the legislature and the Governor, which is no different than any other study committee which is created by the legislature. However, again this would involve much time and effort in making up such a report, which, as stated above, would result in higher costs, which is what we are trying to avoid.

I know that some will argue that Section 3 has a sunset provision that the commission will expire on December 31, 1986. However, having been a past member of the legislature, I have seen this provision in many study committees. These either have been reinstated at the end of the sunset period at the request of the legislature or at the request of the committee, which normally submits to the legislature that it has not completed its studies and needs more time to do so. Again, this results in increased appropriations.

Members of the committee, I submit to you that this matter can be studied for decades, and that the recommendation and final report entered by any study commission will be the same.

KHVE is not here today to take issue with the intent of Senate Bill 285, but merely to point out to this committee that rising health-care costs is a matter which should be left to the professionals in the field. I believe that every committee member knows that it is not the desire of any of the hospitals in our state that health-care costs spiral out of control. It is certainly not conducive to good business to let this happen if there is any type of prevention available. The hospitals are

caught in the same dilemma as all other businesses in this state and in this country. That is that the rising costs for production of good health care and maintenance have forced the hospitals to implement those increases, only to recover their costs. I am sure that the committee is well aware, and it can be documented, that the hospitals today do not have a larger net operating budget than they have in the past, but only implement additional costs to help curb the inflationary rate at which the hospitals' expenses are increasing.

Thank you for your consideration in this matter. I know the committee will act in the best interest of the citizens of this state in its consideration of Senate Bill 285.

Respectfully submitted,

BOB W. STOREY

2-28-83

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KANSAS HOSPITAL ASSOCIATION

TESTIMONY

SENATE BILL 285

February 28, 1983

Madam Chairman and members of the Committee, the Kansas Hospital Association appreciates the opportunity to testify on Senate Bill 285. Senate Bill 285 presents an interesting concept. It might be appropriate for a group to be assembled to study the factors affecting health care costs in Kansas and to provide recommendations in the form of a report that could be used by state government and the legislature in creating health care policy in Kansas.

Senate Bill 285 speaks to creating a commission of some duration; and speaks to giving this commission authority to require the provision of supporting information. The bill also establishes an open ended fiscal note which would be the responsibility of providers. We are opposed to these provisions for the following reasons.

In general, we see no major difference between the responsibilities of the existing Statewide Health Coordinating Council (SHCC) and those six study topics set forth in Section 1(a) of this bill. In an era of strict budget constraints, the Hospital Association feels that a commission such as the "State Health Care Commission" established by Senate Bill 285 would be costly and duplicative of the SHCC. While the SHCC is slightly larger than the 11 member commission described in Senate Bill 285, the composition of its membership is very similar. The SHCC, through the Office of Health Planning, already has the authority to collect information. The SHCC has also been well educated through its experience in the intricacies of the

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health care delivery system. To establish a similar group of people with a similar, if not identical, charge is unnecessary.

The Association's position regarding Senate Bill 285 is that the concept has merit and should be explored. However, we question whether this legislation is necessary. Instead, the Association would make the recommendation to establish a steering committee to include the Insurance Commissioner, the Secretary of S.R.S., the Secretary of Health and Environment, a representative of the Kansas Hospital Association, the Kansas Medical Society, Blue Cross and Blue Shield of Kansas and the Governor's office. This steering committee would investigate the experiences of other state commissions and how they have functioned in addressing the issue of factors affecting health care costs. It would also explore the operations of such a commission, including funding and make a recommendation to the Governor's office as to whether or not this type of organization would be appropriate in Kansas. The Association would also like to recommend that if a commission is established by the Governor, a short duration should be identified--something that would produce a deadline for the commission to target its report. Our suggestion would be that the study be concluded by June 30, 1984.

Senate Bill 285 appears to do no more than establish another level of bureaucracy on which to review and study the factors affecting health care costs in Kansas. In its place we would recommend that a steering committee be established to research the best way for a commission to be set up, make a recommendation to the Governor's office, and allow the Governor to establish a commission.

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KANSAS HOSPITAL ASSOCIATION

TESTIMONY

SENATE BILL NO. 87

Madam Chairperson and members of the Committee, the Kansas Hospital Association is pleased to have the opportunity to provide testimony on Senate Bill 87. The Association and its members are opposed to Senate Bill 87 and urge that it not be passed.

We are opposed to this "cost containment" initiative for several reasons. First of all, there are a number of current efforts being undertaken by the major payers of health care in Kansas, those being Medicare, Medicaid and Blue Cross, that basically set, or will set, hospital rates. These three payers represent almost 80% of the payments to Kansas hospitals for services provided.

In Medicare, for instance, new regulations implemented as a result of the Tax Equity and Fiscal Responsibility Act of 1982 and effective on October 1, 1982, limits reimbursement for inpatient hospital services in 1983 to approximately 108% of the 1982 costs. Over the next two years Medicare reimbursement will continue to be limited to HCFA's hospital market basket index plus 1% for technology. Congress also mandated the Health Care Finance Administration to develop a prospective payment system for Medicare. HCFA has already submitted its proposal for such a payment system. It is anticipated that a prospective Medicare payment system, with a fixed national payment rate by diagnostic related groups (DRG's), adjusted for local circumstances will be in effect by October 1, 1983. The Kansas Hospital Association supports this effort.

With respect to Medicaid, the Kansas Hospital Association has been meeting with Secretary Harder over the past year in the process

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of negotiating a prospective payment system for Medicaid. This process is unique among states and reflects the very positive spirit of cooperation that has developed between the Department of Social and Rehabilitation Services and the hospitals of Kansas. Agreement has been reached through a Memorandum of Understanding with SRS and the Kansas Hospital Association for a prospective payment system that will accommodate the budget constraints in the Medicaid program. The hospital industry was pleased to work out an arrangement for providing hospital services to Medicaid recipients during a period when the State is dealing with limited resources. However, it must be pointed out that the agreed upon payment rate for services provided to Medicaid patients is somewhat less than the actual cost to the hospitals.

The other major payer in Kansas, Blue Cross and Blue Shield, is committed to the creation of a new prospective payment system which will provide payment to hospitals based on diagnostic-related groups, or DRG's. This system will basically establish, by diagnosis, a rate for hospitals in each peer group and all hospitals within a given peer group will be reimbursed at the same rate.

As I have just briefly explained, 80% of the payments for hospitals in Kansas already are subject to some form of rate setting. The establishment of a commission, therefore, is redundant, and merely adds to the rate setting initiatives that are already taking place.

With respect to state rate review commissions, I would also like to point out to the committee, the experiences of our neighboring state, Colorado. In the late 1970's, a Colorado Hospital Commission was established. The legislation you have before you is very similar, if not identical, to the makeup of that Commission. The Colorado Commission was plagued with problems from the very beginning which

resulted from a Commission staff that was unable to handle the complex job and excessive bureaucratic redtape created by the Commission. An example of this "redtape" was the uniform accounting system required by the Commission. These reports were generally seventy to one hundred pages long and were extremely burdensome, especially to the small, rural hospitals with limited staffs and resources.

An interesting highlight is that one of the Senators who originally sponsored the bill, Senator Fred Anderson, ultimately introduced the legislation in 1979 to repeal the Commission. Thus, in just a year after its inception, the Colorado Commission was repealed. In fiscal year 1979, the costs for operating the Colorado Hospital Commission were approximately $450,000. A similar effort today, would incur a much larger cost, perhaps, even doubling Colorado's $450,000 cost experience. Today it would not only be costly to hire the staff qualified to meet the requirements of a commission, but also to address the complexity necessary in a new payment system. As the industry switches from traditional cost-based systems to systems dependent upon establishing prospective payment rates for 467 different diagnostic categories, it is obvious that we all will have to develop much more sophisticated systems for management, monitoring and reporting.

Given these new developing systems, establishing a Commission as proposed by the legislation, will force hospitals to maintain at least two completely separate sets of records in order to accommodate both the Commission and the other third party payers. This alone is not in keeping with the spirit of cost containment.

To summarize our opposition to Senate Bill 87, first of all currently the major third-party payers account for 80% of the payments to Kansas hospitals. Each of these major payers are already developing new prospective payment systems that will establish payment rates for Kansas hospitals. Secondly, an effort almost identical to Senate Bill 87 was attempted in Colorado, a state which is similar to Kansas in many demographic aspects. The Colorado Commission was a complete failure because it created an expensive, burdensome, bureaucratic nightmare. The final reason for our opposition is the high cost of establishing such a commission--both to the State and the Kansas hospitals.

In closing, I think we can surely say that we are coming into a period where the reimbursement to hospitals will be reduced and we will see significant reductions in the rate of increase in health care costs. I can assure you that the industry is posturing itself to operate within these limited resources.

State rate commissions are not in step with current third-party payer initiatives. Therefore, the Kansas Hospital Association urges you to allow the major payers to continue to develop their systems of prospective payment. This will, in effect, set what rates will be paid for hospital care, and still not impose yet another layer of bureaucracy on the industry.

Again, thank you for the opportunity for allowing us to express to you our concerns on Senate Bill 87.

February 28, 1983

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THE KANSAS PHARMACISTS ASSOCIATION
1308 WEST 10TH
PHONE (913) 232-0439
TOPEKA, KANSAS 66604

KENNETH W. SCHAFERMEYER, M.S., CAE
PHARMACIST
EXECUTIVE DIRECTOR

DATE: February 28, 1983

TO: Senate Public Health & Welfare Committee

FROM: Kenneth W. Schafermeyer, M.S., CAE
Executive Director

SUBJECT: Senate Bill 285 - State Health Care Commission

The Kansas Pharmacists Association cannot support Senate Bill 285 as written.

Since there is support for SB 285, we feel that at least one specific item needs to be changed. This bill would establish a health care commission to study medical necessity of health care services, the quality of services, and the reasonableness of charges for services. We feel that to list a separate purpose to "implement statutory cost control measures with respect to the sale and purchase of prescription drugs and the purchase of medical equipment and supplies" is redundant, misleading and unnecessary. We recommend the following amendment: Item No. 5, beginning on line 33 of the bill, should be deleted and No. 6 should be renumbered as No. 5. With this change the proposed state health care commission would still be able to study "the reasonableness of charges made for the rendering of health care services" as described in Item No. 3, line 27 of the bill including prescription drugs. This would be a significant improvement in the bill since it removes inflammatory and misleading language. Both Mr. Todd and Mr. Brock of the Insurance Commissioner's office agreed to this amendment.

Pharmacists are very concerned about increasing health care costs and have a great deal to offer to this type of study. Although prescription drugs account for only 6.5% of the health care dollar, they are undoubtedly the most cost effective health care investment since they often prevent the more expensive health care services such as institutionalization in a hospital, nursing home or mental health facility.

We feel that the State of Kansas would benefit from a thorough review the of cost of health care in Kansas. Since there are a number of ways that this can be done both within and outside of state government, we are not sure that it is necessary to legislate such a commission. Another alternative may be the Kansas Business Coalition on Health which was recently formed by the KACI which has similar purposes.

Thank you very much for considering our comments.

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BY-LAWS

KANSAS EMPLOYER COALITION ON HEALTH, INC.

ARTICLE I

NAME AND ORGANIZATION

1.01 Name. The name of this organization shall be "Kansas Employer Coalition on Health, Inc." which shall be referred to herein as the "Corporation".

1.02 Organization. The Kansas Employer Coalition on Health, Inc. is and shall be organized as a Kansas not-for-profit Corporation.

ARTICLE II

PURPOSE

2.01 Purposes. A. To promote, encourage, and provide a mechanism through which employers can voice their concerns about the health care system, its organization and its costs.

B. To conduct studies and research, in the public interest, concerning the efficiency and effectiveness of the health care system. The results of the Corporation's research shall be made available to the public on a non-discriminatory basis whenever practicable.

C. To provide information to members in health benefits, health promotion and other areas relevant to the cost of health care.

D. To conduct educational seminars, conferences, and public forums on issues relating to health care costs and health care services delivery. Such educational activities will be open to the public without discrimination on any basis.

1980: Consumer Price Index Again Outpaces Rise in Rx Price Index

John M. Firestone, Ph.D., Professor Emeritus
City University of New York

► Since 1960, all consumer prices have risen 178.2%, and medical care prices (including prescriptions) have risen 236.2%. During this same period, prescription prices have risen 34.3%, according to the U.S. Bureau of Labor Statistics (BLS) or, as measured by the Pharmaceutical Manufacturers Association (PMA), 31.5%. During the period of increased Rx prices (since 1974), all consumer prices and total medical prices have risen more rapidly than prescription prices. This is very true for every period of comparison.

Since 1978, the period of double-digit inflation in the total economy, prescription price increases have been considerably more modest in terms of percent changes amounting to 7.2% (PMA) or 9.2% (BLS).

The PMA index list not only includes far more drugs than the BLS list, but in many instances the product's price is often measured by a number of the multiple manufacturing sources from which the product is available. This makes for a more accurate reflection of price conditions in the total market than is possible with BLS' sample. Rx ⇌ OTC

[illegible]

	Indexes (1967=100)				Percent change in 1980 since:			
	CPI			PMA	CPI			PMA
Year	All	Med.	Rx	Rx	All	Med.	Rx	Rx
1960....	88.7	79.1	115.3	111.8	+178.2	+236.2	+ 34.3	+ 31.5
1970....	116.3	120.6	101.2	101.3	112.2	120.5	53.0	45.1
1974....	147.7	150.5	102.9	105.3	67.1	76.7	50.4	39.6
1975....	161.2	168.6	109.3	112.2	53.1	57.7	41.6	31.0
1976....	170.5	184.7	115.2	116.9	44.8	44.0	34.4	25.7
1977....	181.5	202.4	122.1	121.9	36.0	31.4	26.8	20.6
1978....	195.3	219.4	132.1	128.7	26.4	21.2	17.2	14.2
1979....	217.4	239.7	141.8	137.1	13.5	10.9	9.2	7.2
1980....	246.8	265.9	154.8	147.0				

Table 1 *Current trends in pharmacy operations*

Averages per Pharmacy	1981 1,750 Pharmacies			1980 2,070 Pharmacies			Amount and Percent of Change	
Total sales	$439,133	100.0%		$416,161	100.0%		+$22,972	5.5%
Cost of goods sold	288,421	65.7%		273,390	65.7%		+$15,031	5.5%
Gross margin	$150,712	34.3%		$142,771	34.3%		+$ 7,941	5.6%
Expenses								
Proprietor's or manager's salary	$ 27,983	6.4%		$ 26,001	6.2%		+$ 1,982	7.6%
Employees' wages	50,689	11.5%		49,128	11.8%		+$ 1,561	3.2%
Rent	10,886	2.5%		10,127	2.4%		+$ 759	7.5%
Heat, light, and power	3,758	0.9%		3,682	0.9%		+$ 76	2.1%
Accounting, legal, and other professional fees	2,079	0.5%		1,966	0.5%		+$ 113	5.7%
Taxes (except on buildings, income, and profit) and licenses	6,706	1.5%		6,254	1.5%		+$ 452	7.2%
Insurance (except on buildings)	4,640	1.1%		4,539	1.1%		+$ 101	2.2%
Interest paid	3,612	0.8%		2,901	0.7%		+$ 711	24.5%
Repairs	1,974	0.4%		1,503	0.4%		+$ 471	31.3%
Delivery	2,206	0.5%		1,984	0.5%		+$ 222	11.2%
Advertising	4,745	1.1%		4,590	1.1%		+$ 155	3.4%
Depreciation (except on buildings)	3,886	0.9%		3,591	0.9%		+$ 295	8.2%
Bad debts charged off	636	0.1%		556	0.1%		+$ 80	14.4%
Telephone	1,588	0.4%		1,463	0.3%		+$ 125	8.5%
Miscellaneous	11,351	2.5%		10,702	2.6%		+$ 649	6.1%
			10.7%			10.6%		
Total expenses	$136,739	31.1%		$128,987	31.0%		+$ 7,752	6.0%
Net profit (before taxes)	$ 13,973	3.2%		$ 13,784	3.3%		+$ 189	1.4%
Total income of self-employed proprietor (before taxes on income and profits)	$ 41,956	9.6%		$ 39,785	9.5%		+$ 2,171	5.5%
Value of inventory at cost	$ 68,768	15.7%		$ 67,020	16.1%		+$ 1,748	2.6%
Annual rate of turnover of inventory		4.3 times			4.2 times			
Hours per week pharmacy was open		62			63		– 1	

NOTE: These national averages are presented to give a composite picture of the average LILLY DIGEST pharmacy. Comparisons for analysis should be based on the operations of pharmacies of comparable sales and prescription size which appear in one of the 31 arrangements in the "Heart of the LILLY DIGEST."

2-28-83 Att. 1

HEALTH SYSTEMS AGENCY

OF NORTHEAST KANSAS

TESTIMONY ON

SENATE BILL 87

AND SENATE BILL 285

PRESENTED TO THE

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

STATE CAPITOL, ROOM 526 S

FEBRUARY 28, 1983

Att. 6

Good Morning, Madam Chairperson Meyers, and members of the Senate Public Health and Welfare Committee. My name is Audrey Kennedy, I am an Assistant Professor of Nursing and member of the Board of Directors of the Health Systems Agency of Northeast Kansas (HSANEK). I am testifying today as a member of the Board of Directors of the HSANEK, with which some of you are familiar. For those of you who are not, the HSANEK is non-profit organization with a 50 member volunteer Board of Directors that has health planning responsibilities in twenty-five counties in Northeast Kansas. Its volunteer Board of Directors has 25 representatives appointed directly by each County Commission and the remaining Board members come from a wide range of rural and urban community groups and organizations.

One of the health planning functions of the HSANEK is to contain the increase of costs in the health care industry, through planning, participation in the Certificate of Need Program , and consumer education (which provides information on physician and hospital services prices).

In view of the primary concerns of the HSANEK, I appreciate this opportunity to present testimony on SB 285 concerning the creation of a state health care commission and SB 87 establishing the Kansas hospital commission. I would like to thank the committee for allocating an additional hour of hearing to this very important issue - health care cost containment - which affects all the residents of Kansas.

The HSANEK would like to urge this committee to pass S.B. 87. However, if S.B. 87 is not passed at least S.B. 285 should be passed as amended by assigning the health care cost study to SHCC.

SB 87

First, I will address commemts to SB 87. In order to understand the magnitude of the the issue of health care cost we should ask ourselves the following question:

WHY IS HEALTH CARE COST A PROBLEM IN KANSAS AND THE NATION?

Health care costs rose around 15% in 1981. They rose about the same amount in 1980. These were the fastest rises in history. In 1981 the rise was three times the rise in the overall cost of living. Hospital costs, a component of health care costs, rose 19% in 1981.

Health care is taking more and more of our individual and our collective resources. Health care costs have increased as a percent of the Gross National Product every year since 1966. Health care costs have increased as a percent of older people's incomes from 16.8% in 1970 to 19.1% in 1980. Older people are hit especially hard by health care cost increases for two reasons. First, they are the biggest users of health care, and second, the public programs, especially Medicare and Medicaid, that help pay for the care, are cutting back. Out of expenditures of about $57 billion, Medicare budget cuts schelduled in law are $4.4 billion in FY 83, $6.2 billion in FY 84 and $7.0 billion in FY 85. The Reagan Administration is proposing another $1.9 billion in FY 84.

Medicare receipients do not absorb all these cuts. Some are shifted to other payors, a few absorbed by health care providers. But, the elderly absorb the bulk of the Medicare cuts, as increased out-of-pocket expenses or as diminished service delivery. One good indication of how much the elderly absorb is the recent increases in Medicare Supplemental insurance rates. Blue Cross/Blue Shield Medicare Supplemental Policy Plan 65 premium rates, for example, rose 24% in 1981, 37% in 1982 and 17% in 1983.

Health insurance for older people is in a state of considerable flux right now. Although we see the need for changes in Medicare, Medicaid, Medicare Supplemental policies and so forth, we do not think these changes should be made completely because of budgetary pressures. But at the federal level, budgetary pressures on Medicare are tremendous and uppermost in the minds of policy makers. These cuts severly threaten the Medicare program.

The State of Kansas should accept a responsibility to ward off this threat. The way it can do so is to take action to contain health costs across the board.

The HSANEK agrees with the basic thrust of Senate Bill 87 -the Kansas Hospital Cost Containment Act. The bill adequately reflects and builds upon the cost containment efforts found to be successful in other states. The Hospital Commission as it is constructed and empowered in the Act can and will directly confront the issue of rising hospital costs. Health planning groups, such as the SHCC and HSAs in their efforts to address this issue have been hampered by three factors: 1) lack of authority, 2) lack of a uniform system of financial reporting, and 3) lack of a mechanism for obtaining information regarding hospital budgets, hospital rates and charges and a system of evaluating hospital performance relative to costs. This bill will enable the Kansas Hospital Commission to gather the relevant information, make meaningful analyses and comparisons, direct the hospital industry into a cost containment mold, and therefore have a direct, positive, and beneficial impact on hospital costs.

Specifically, Section 6 (a), line 151-152 of the proposed SB 87 should be amended to read "from the date that the Commission is fully staffed or operational". Since it takes six to eight months to develop and staff a newly

formed organization. This amendment will ensure that the Commission will have adequate time to complete the task of developing a uniform system of financial reporting.

In addition, SB 87 should address the vehicle for funding and the fiscal note to operate the proposed Commission. Further, the HSANEK proposes to amend Section 5 (b) Line 99 to read, "The Advisory Committee shall be the SHCC."

The passage of S.B. 87 will be beneficial to Kansans by reducing the increases of health care costs. Therefore, HSANEK stongly supports S.B. 87 as amended.

SB 285

Second, I will address my comments to S.B. 285. A brief historical backgound on the efforts by the Kansas Legislature in tackling this issue will enable us to focus on the importance of the proposed State Health Care Commission and its functions.

The Kansas Insurance Commissioner is interested in health care cost containment. He has tried to get the Kansas Legislature to give his office the authority to control all insurer's rates, but has not been successful.

Further, the Kansas Legislature has shown concern over health care costs increases in recent years. In its 1980 session, it enacted H.B. 2756, which requires that Blue Cross/Blue Shield devote a reasonable effort to controlling costs. The 1981 Interim Committee on Public Health and Welfare spent a four day session hearing from conferees and discussing the problem of health care cost increases. The Committee concluded that "costs would not be contained in the near future". The year before, 1980, a special committee on health care cost containment heard from representatives of prospective rate review programs in Maryland, Washington, Wisconsin and Indiana. That committee reported out H.B. 2750, which set up a rate review commission to evaluate Blue Cross's rate review and set rates for hospitals not participating in the Blue Cross program. However, the Bill did not pass.

The Statewide Health Coordinating Council (SHCC) has been and continues to be interested in health care cost containment. Over the past four years the State Office of Health Planning (which serves as SHCC's staff) has studied and developed a health care costs plan component to the State Health Plan. Further, it has presented testimony to Senate and House Legislative Committees on the issue of health care cost containment.

Obviously health care costs need to be contained. There is widespread agreement on that point from the purchasers of health insurance (businesses) to the providers of health care (physicians, hospitals). On the other hand, agreement falls apart on how cost containment in the health care industry should be accomplished. The proposed commission might be able to bring about concensus on health care cost containment solutions. On the other hand, the proposed commission has the disadvantage of being time limited, therefore, will not have sufficient opportunity to monitor, evaluate and revise plans. A time limited organization will not be around over the long term to evaluate and monitor and revise plans.

Currently, the Statewide Health Coordinating Council (SHCC) does very similar work. It is difficult to see how this commission would be different from the SHCC. This committee should seriously think of assigning to the SHCC the study of health care costs along with the authority to get uniform cost information from providers. There may be more incentive to the SHCC to conduct the study if there is a Legislative charge: to address the question of health care costs and to report to the Goyernnor and the Legislature, within a specified period of time. In the past the SHCC has conducted studies for the Legislature on various health care issues. Further, the SHCC has 30 members appointed by the Governor who represents both consumers and providers of health care. It is the opinion of the HSANEK that the SHCC could serve the function of the proposed commission.

Consequently, the HSANEK supports passage of an amended SB 285, which would assign the health care cost study and the authority to collect uniform data to conduct the study to the SHCC. I would like to thank you for the opportunity to provide this testimony. I will be happy to respond to any questions you may have.

2-28-83 #7

Kansas Farm Bureau, Inc.

2321 Anderson Avenue, Manhattan, Kansas 66502 / (913) 537-2261

MEMORANDUM

TO: Senator Jan Myers, Chairperson
Senate Committee on Public Health and Welfare

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

SUBJ: Opposition to S.B. 87

DATE: February 28, 1983

Senator Myers, we are providing to you a sufficient number of copies of this brief memo and short statement on behalf of Kansas Farm Bureau in opposition to mandatory health care cost control, the topic of S.B. 87. We would appreciate it very much if this memo and our statement could be made a part of the record of the Senate Committee on Public Health and Welfare as you consider S.B. 87. Regrettably, my duties will require me to be out of state while you conduct the hearing on this bill.

Our members are concerned about increasing health care costs. They're concerned as well about the number of governmental rules and regulations already placed on hospitals and health care providers. Our concerns and the reasons for them are outlined in our short statement in opposition to S.B. 87. At the conclusion of our statement you will find the adopted policy position of the voting delegates from 105 counties representing the membership of our organization. The policy position was adopted at our most recent (December 5-7, 1982) Annual Meeting.

Thank you very much for sharing our views with members of your Committee.

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Atch. 7

STATEMENT TO THE
SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

RE: S.B. 87
February 28, 1983
Topeka, Kansas

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

Mr. Chairman and members of the Committee, thank you for an opportunity to again express to a committee of the Kansas Legislature the feelings of Farm Bureau members relative to hospital and/or health care cost control. In reviewing this subject with your Committee, I would like to indicate our clear opposition to S.B. 87. The Kansas Farm Bureau organization has carried a legislative position in its Resolution Book since 1979 opposing any form of mandatory health care cost control. During that time, we have had a number of members involved in voluntary health care cost-containment efforts.

The presence of the statement entitled "Mandatory Health Care Cost Control" in our current *Resolution Book or a similar resolution for the past five years, stems from a membership very, very concerned about health care costs. Quite frankly, however, any study of this issue by our membership has ended with a firm conviction that many of the health care cost concerns now facing our state and nation stem from an already overinvolved government in the delivery of health care services via federal insurance reimbursement requirements or statutory staffing requirements. To add to the already frustrating economic picture facing Kansas hospitals the form of jurisdiction as would be developed by Senate Bill 87 would not allow the best continuance of quality health care service in Kansas.

We believe there will be some very significant changes in the operation of Kansas hospitals in the next 18 to 24 months - particularly those small and rural hospitals with a high percentage of Medicare patients. The '83 Medicare reimbursement policies will force many hospital boards and patrons to seriously question the continuance of health care service as now provided in our smaller communities. The economics of survival will be the issue forcing all hospital communities to establish a rate and budget structure with strong cost-containment limits or a plan of closure. Whether we supported the philosophy of establishing a State Hospital Review Authority seems a question past its prime. The efficient hospitals will survive with much more planning, staffing, and commitment to budget and rate development. The addition of a Kansas Mandatory Rate Authority will do nothing but add to the health care costs "bottom line" in Kansas, another item of costly bureaucratic review and management.

We are thankful for the opportunity to explain our policy position shown below:

**Mandatory Health Care Cost Control*

Spiraling health care costs warrant serious consideration by private citizens and health care professionals alike. Government mandated cost-containment legislation will not provide the best answer to this dilemma. We will continue to support voluntary leadership in the area of health care cost control.