Approved March 13, 1984
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

10 a.m./p.m. on February 29, 1984 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

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

Conferees appearing before the committee:

Jerry Hannah, Department of Social and Rehabilitation Services
Kay Mettner, Executive Director, Mental Health Association of Kansas
Al Olson, Families for Mental Health
Paul Klotz, Executive Director, Community Mental Health Centers of Kansas
George Heckman, Kansas Association of Alcohol and Drug Program Directors
Dr. Richard B. Maxfield, President, Kansas Psychological Association
Howard W. Snyder, Families for Mental Health, Inc.
Ron Mersch, Legislative Chairman, Drug and Alcoholism Council of Johnson Co.
Gene Johnson, Kansas Community ASAP Coordinators Association
Jack Roberts, Blue Cross-Blue Shield
David Burk, Board of Directors, Kansas Employer Coalition on Health
Walt Whelan, Vice President, Pyramid Life Insurance Co, Prairie Village
L. M. Cornish, Domestic Life Insurance Corporation, Topeka

Others present: see attached list

SB 780 - Mental health centers, licensing requirements

Jerry Hannah, Department of SRS, distributed testimony to the committee in support of SB 780, stating that this bill is a technical change only which will maintain the status quo. (Attachment #1).

Senator Ehrlich moved that SB 780 be reported favorably and placed on the Consent Calendar. Senator Morris seconded the motion and it carried.

SB 781 - Insurance for alcoholism, drug abuse or nervous or mental conditions

Kay Mettner, Executive Director, Mental Health Association of Kansas, testified in support of SB 781.

Al Olson, Families for Mental Health, testified in support of SB 781.

Jerry Hannah, SRS, testified in support of SB 781, and distributed testimony stating that SRS would support this bill because it would enable community mental health centers to recover their fair share of the costs for psychiatric and substance abuse services by preventing the further decline in insurance coverage for these services. (Attachment #2).

Paul Klotz, Executive Director, Community Mental Health Centers of Kansas, testified in support of SB 781, and distributed testimony stating that the primary reason CMHCK supports this bill is to improve access for those in need of psychiatric treatment. The real freedom of choice needed is not whether to purchase insurance, but rather the freedom to choose appropriate treatment when needed. Sixty percent or more of the visits to medical doctors are made by patients who have a stress or emotional

related problem. Current national, state and local data contradict the fears of the insurance industry that this bill will result in over-utilization, runaway costs and abuse. Fourteen states now have mandates and none of these states report over-utilization or abuse. Mr. Klotz said SB 781 can be cost effective and cost containing. (Attachment #3).

George Heckman, Kansas Association of Alcohol and Drug Program Directors, testified in support of SB 781 and distributed testimony stating that the KAADPD strongly supports this bill and giving the results of a five-year study in California on the potential benefits and projected costs of providing mandatory insurance coverage of alcoholism and drug dependency. (Attachment #4).

Dr. Richard B. Maxfield, President, Kansas Psychological Association, and a Certified Psychologist, testified in support of SB 781, and distributed testimony to the committee which stated that there is clear data that mandating mental health coverage will not lead to skyrocketing utilization or costs of such services, and the reduction of human suffering available to consumers through mental health treatment is ample reason to justify this proposed legislative mandate. (Attachment #5). Dr. Maxfield also distributed a letter from Dr. W. Walter Menninger supporting HB 2795, a a House bill with similar provisions to SB 781. Dr. Menninger testified before the Insurance Committee of the Kansas House of Representatives in support of this bill. (Attachment #6).

Howard W. Snyder, Families for Mental Health, Inc., Johnson County, testified in support of SB 781, and distributed testimony stating that mental illness is a legitimate illness and should be insured on the same basis as the traditional physical illnesses. It is time to realize that this segment of the population has as much right to be insured as does the rest of the population. Mr. Snyder also submitted copies of two newspaper editorials concerning insurance coverage for the mentally ill. (Attachment #7).

Ron Mersch, Legislative Chairman, Drug and Alcoholism Council of Johnson County, testified in support of SB 781, and submitted written testimony stating that passage of this bill will enable more people to receive needed treatment through the increased availability of adequate insurance coverage, and will have its greatest impact on the middle income/working class population. While mandated insurance coverage for substance abuse treatment is not a total solution to the problem, it is a necessary component. (ATtachment #8).

Gene Johnson, Kansas Community ASAP Coordinators Association, testified in support of SB 781, and submitted testimony stating that their organization feels that an insurer which offers coverage for accident and sickness should cover a disease which has been recognized for over thirty years by foremost health organizations - that disease being alcoholism. They feel that this bill will be a positive step forward in the treatment of alcoholism and drug addiction, and will lend support to the campaign against the drinking/driver offender. (Attachment #9).

Jack Roberts, Blue Cross-Blue Shield, testified in opposition to SB 781. Mr. Roberts said that this bill would greatly increase health care costs, and distributed a list of Estimated Additional Annual Costs i n various categories to add outpatient Psychiatric Rider to Blue Cross-Blue Shield Contracts. In order to offer this coverage to Non-Group and Plan 65 subscribers it would be necessary to impose restrictions such as waiting periods and to increase the subscriber's share of cost in the coinsurance. (Attachment #10).

David Burk, Board of Directors, Kansas Employer Coalition on Health, testified in opposition to SB 781, and distributed testimony stating that for any employer and for KECH, a cost containment strategy includes action toward reducing consumer demand; creating efficiency incentives; and controlling resource supply. KECH believes that this bill runs counter to all of these objectives. The existing law giving employers the option to provide such coverage is consistent with the KECH goal of redesigning

benefit packages to reflect the true needs of employees. KECH urges the committee to reject SB 781. (Attachment #11). Mr. Burk also distributed an article from the New England Journal of Medicine entitled "Does Free Care Improve Adults' Health" and an article from the New York Times, "Flex-Time Weaves Job and Family". (Attachment #12).

Walt Whelan, Vice President, Pyramid Life Insurance Company, Prairie Village, testified in opposition to SB 781, and stated that he opposed the state mandating any levels of benefit and felt that this was a hidden tax. Mr. Whelan maintained that the way this bill is written circumvents the deductibles, and should be rewritten.

L. M. Cornish, Domestic Life Insurance Corporation, Topeka, testified in opposition to SB 781, and said that he subscribed to the views already stated.

Written testimony in support of SB 781 was presented to the committee by: Betty Stowers, Mental Health Association of Kansas; James A. McHenry, Jr., PhD., Alcohol and Drug Abuse Commission; Glenn Leonardi, Kansas Alcoholism and Drug Abuse Counselors' Association; Bruce Beale, Chairman, Kansas Citizens Advisory Committee on Alcohol and other Drug Abuse. (Attachment #13).

Written testimony in opposition to SB 781 was presented to the committee by: William E. Horn, Group Claim Manager, Wichita, for Bankers Life of Nebraska; Marsha Hutchison, Beech Aircraft Corporation. (Attachment #14).

Elizabeth Taylor, Kansas Association of Domestic Violence Programs, distributed to the committee a Summary of Domestic Violence Program Funding. (Attachment #15).

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-29-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
L.M. CORNISH	KS Life Assoc.
W.W. WHALEN	Pyramid Life Ins Co
Keith Hawkins	" " "
Johanna R. Fox	Kansas Nursing Students
Jim McBride	United Way of Topeka
Kay Mellor	MHMR
Becky Peterson	Assoc. of CMHCs of KS
Catherine Richardson	Washburn U. Student Nurse
Melissa Voss	W.U. Student Nurse
Paul M. Klotz	Assoc of CMHCs of Ks
Chris Hall	WU Student nurse
Ellen Ellis	KSNA Dist II
[illegible]	WUNS, Topeka
[illegible]	WUNS, Topeka, KS
John Robertson	WU Student nurse, Topeka
APRIL VONGEHLEN	WUNS
Janet Smith	KSNA - Topeka
Virginia Hart WUEmporia KS	Emporia KS
Harold Ast	WUNS
Nelson Hayden	WUNS
Deborah Ks	WUNS
Kari Schmidt	WUNS
Lisa Smith	WUNS

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-29-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Lori Meyer	WUSN
Lesa Hughes	Wichita
Nicole Stein RN	KS State Nurses' Assn.
Marion Metzler RN	KSNA
John Peterson	Ks Assn Professional Psychologists
[illegible]	Mid-Kansas Family Ctr. Ltd.
Rep. Gary Blumenthal	
Pamela Bell	Kansas State Nurses Assoc.
Pat Hegarty R.N.	KSNA
Rajean Howard	WUNS
Mindy Mitchell	KSNA
Kathy Jessee	KSNA
MJ Poehler	WUNS
Bill Mock	WUNS
Barbara Woodward	WUNS
Rose M Krahn	WUNS
Glen Leonardi	Ks Assn. of Alcoholism & Drug Abuse Counselors
Pat Thompson	KSNA
Hazel Harvey	KSNA
David Wiebe	Shawnee Community Mental Health Center
Robert L. Anderson	Family Consultation Service
Jeanne Youngberg	KU Center for Public Health Education & Office
Dub Rakestraw	Family Service & Guidance Center Topeka

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE____________________

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Dr. George [illegible] Commissioner	SRS MH/MR Services

#1 — 2-29-84

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Statement Regarding Senate Bill 780

I. Short Title of Bill

This bill relates to the definition of community mental health centers as it relates to licensing requirements. This bill amends K.S.A. 1983 Supp. 75-3307b.

II. Background

This legislation is being introduced because it establishes in fact what has been done in practice. It relates to two counties and four centers which have been in existence for at least twenty-five years and have been licensed as community mental health centers.

III. Discussion

This bill will affect four mental health centers; three in Sedgwick County which are Family Consultation Service, Wichita Guidance Center, and Holy Family Center and one in Shawnee County which is Family Service and Guidance Center of Topeka, Inc. This bill will not increase or decrease the number of providers. It does not alter licensing standards other than establishing for these four centers the provision for licensure as long as they remain affliated with community mental health centers and continue to meet licensure standards. There is no fiscal note to the state. The Association of Community Mental Health Centers and Mental Health and Retardation Services are in support of this bill. Lastly, this bill is a technical change only.

IV. SRS Position

The Department of S.R.S. supports this technical change which will maintain the status quo.

Robert C. Harder, Secretary
Office of The Secretary
Social and Rehabilitation Services
296-3271
February 28, 1984

Atch. 1

#2 - 2-29-84

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Statement Regarding Senate Bill No. 781

I. Short Title of Bill

The bill relates to insurance reimbursement for treatment of alcoholism, drug abuse or nervous or mental conditions. This bill amends K.S.A. 40-2105 and repeals the existing section which permits every insurer unless refused in writing to include psychiatric coverage and treatment of alcohol and drug abuse in their insurance coverage.

II. Background

This legislation is being introduced to mandate minimum insurance coverage for psychiatric illness and treatment of alcohol and drug abuse for all Kansans holding group or individual medical policies. During the last few years the trend has been to reduce benefits for psychiatric illness and substance abuse problems. This bill will help prevent the future decline in third party coverage for psychiatric and alcohol and drug abuse problems. If the trend toward decreased insurance coverage is not reversed, the financial status of community mental health centers that provide psychiatric and substance abuse services will certainly be adversely affected. Under present statutes minimum mental health insurance coverage is included in insurance policies however an employer may delete the coverage for mental illness. Senate Bill No. 781 will make coverage mandatory in all employee policies.

III. Discussion

A benefit for the citizens of Kansas will be that they will have more choices for psychiatric care. Currently 60% of general medical care patients have emotional rather than organic bases for the physical symptoms. By having mandated coverage, consumers will be more likely to respond to a referral for mental health services and not over utilize general medical service. In addition, by having outpatient mandated coverage many consumers will choose to get psychiatric care on an outpatient basis through community mental health centers rather than waiting until problems increase and inpatient hospitalization is required. In addition, in a time when the insurance industry is making cuts in coverage provided as a cost saving, this legislation will prevent further cuts in psychiatric and drug abuse coverage for our citizens.

IV. SRS Position

The Department of Social and Rehabilitation Services would support this bill because it would enable community mental health centers to recover their fair share of the costs for the psychiatric and substance abuse services they provide by preventing the further decline in insurance coverage for these services. Lastly, it is important that our agency advocate for our citizens that suffer from mental illness and substance abuse problems since they can not advocate for themselves.

Robert C. Harfder, Secretary
Office of the Secretary
Social and Rehabilitation Services
296-3271
February 29, 1984

Atch. 2

#3- 2-29-84

TO:

THE SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE

ON

SENATE BILL 781

JAN MEYERS, CHAIR

Testimony

of

Paul M. Klotz

Executive Director

Association of

Community Mental Health Centers of Kansas

820 Quincy/Suite 416

Topeka, Kansas 66612

Atch. 3

-BACKGROUND-

The Association of Community Mental Health Centers (CMHCs) of Kansas, on behalf of current and future patients, urge your support of S.B. 781 as written.

The Association represents all mental health centers in Kansas. Thirty-two licensed centers serve every county in the State. These centers receive funding from a variety of sources. The chief, single source of revenue is "out-of-pocket", privately paid fees. Centers also receive funding from federal, state and local governments. Public funding is necessary because centers are, by law, required to serve all Kansas citizens seeking treatment, regardless of their ability to pay. (See attached information sheet on mental health centers.)

- Centers have a proven record of providing quality economical services to over 80,000 Kansans per year.
- Center services range from 24 hour emergency contacts to inpatient services. However, centers are primarily providers of outpatient services.
- Generally speaking, outpatient services are 49 times **less** expensive than inpatient.
- Because of the range of services, centers can provide extremely economical care and treatment of the mentally ill.
- Revenue sources for CMHCs are relatively stable and consistent except for private pay insurance.
- One of the primary goals of centers is to divert patients from unnecessary institutionalization. In fact, over the past 6 years, centers have had a formal agreement with SRS to divert and deinstitutionalize patients.
- Centers are heavily regulated by federal, state and local governments. The Association has its own peer review system, sanctioned by SRS, to control qualifications of professionals who practice in mental health centers.

-THE ISSUE-

The primary reason this Association supports **S.B. 781** is to improve access for those in need of psychiatric treatment. The general community has increasingly recognized that mental illness, drug and alcohol abuse are in fact illnesses. Generally, the health care insurance industry has not fully recognized the fact.

The fundamental principle of insurance is to share the risks or the costs of providing acute health care among the insured populations. Such a principle does not regularly seem to apply to mental health care and treatment.

The real freedom of choice needed is not whether to purchase insurance, but rather the freedom to choose **appropriate** treatment when needed.

The issue is not so much mandating new and untried benefits, but rather the need to

include the concept of holistic care and treatment. Can it be argued that the mind and nervous system are not a part of our being?

No one can argue, in the face of massive evidence, that stress is not a major contributor to general health problems.

The mental health system is primarily and heavily involved in the proper management of stress as it affects the body, mind and nervous system.

Sixty percent or more of the visits to general **medical** doctors are made by patients who have a **stress or emotional** related problem as opposed to an organic basis for their physical symptoms.

- THE COSTS -

Current national, state and local data overwhelmingly contradicts the fears of the insurance industry which seem to say that the provision of mental health outpatient benefits specifically and inpatient benefits generally, will result in over-utilization, runaway costs and abuse.

Blue Cross/Blue Shield in Kansas, having only 24 percent of subscribers covered, estimate that coverage costs an individual policy holder $30 per year or 8¢ per day.

Without arguing whether the $30 per year cost to the consumer is too high or too low, surely the total costs to the consumer has to be reduced if the total pool of risk is increased by 76 percent.

Appropriate outpatient mental health treatment has a definite affect on lowering the use of other medical services. The findings of major research overwhelmingly indicate that appropriate mental treatment results in decreases in physician visits, lab tests, x-rays and hospitalization. Reductions ranged from 5 to 85 percent with a median of 20 percent.

The care and treatment of the mentally ill is largely a burden to the patient, their families, or the tax paying public. Federal, state and local governments provide over 60 percent of all funds for such care. Private health insurance provides only 12 percent of all mental health payments compared to paying 26 percent of all medical expenses.

In recent national studies that compare states with and without mandates, it was found that increases in the cost and utilization of outpatient mental health services was raised, on the average, 15 percent. This is true in Kansas as well when comparing the populations who have psychiatric coverage and those who do not.

Fourteen states now have mandates, of one type or another. None of these states report over-utilization or abuse.

Limitations found in current law and S.B. 781 have equal or more conservative limitations compared to other states which have mandates.

- THE CONSUMER -

Emotional illness accounts for more absenteeism from work than any other illness, except the common cold.

The social stigma of mental illness deters more people from mental health treatment than cost. This same stigma prevents many from seeking insurance coverge.

All national studies indicate that one in five people will require some type of mental health intervention at some point in their life.

Why should many of the emotionally ill and their families have the added burden and stress of being singled out as a population denied the choice of adequate health care coverage?

A few years ago, when the category of professional licensed social workers were added as a providing group, we were told by the insurance industry that the costs of premiums would rise dramatically. Blue Cross/Blue Shield, when asked about the increased costs for social workers, said that the actual costs have been minimal.

The single most frequently asked question in a mental health center is; "Oh, you mean my insurance won't cover this, why?".

On behalf of these clients, we also ask "Why?".

Thank you!

NOTE: Those wishing a packet of materials containing national studies and statistical reports, should contact Paul Klotz at 913-234-4773.

INFORMATION SHEET
COMMUNITY BASED MENTAL HEALTH SERVICES

Association of Community Mental Health Centers of Kansas, Inc.
820 Quincy / Suite 416
Topeka, Kansas 66612
(913) 234-4773

WHAT IS COMMUNITY MENTAL HEALTH?

- Under K.S.A. 19-4001 et. seq., 32 licensed community mental health centers (CMHCs) are currently operational in the state. These centers have a combined staff of over 1,200 providing mental health services in every county of the state and are an integral part of the total mental health system of Kansas. Federal support has been drastically reduced or eliminated, thus posing a very real threat to the continued delivery of some of the services provided by these centers. Growth in Medicaid funding for community mental health care has been reduced over the past two years.

- The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to the mentally disabled in the least restrictive environment. Many arguments can be advanced for treatment at the community level, chief of which is to keep individuals functioning in their own homes and communities, and at a considerable reduced cost to them and/or the taxpayer.

WHO NEEDS IT?

- Between 350,000 (15%) to 468,000 (20%) of the Kansas population are suffering from varying degrees of mental disabilities that require treatment. The combined private and public sectors of mental health treatment are probably not reaching all of those needing service.

- Demand for community based mental health care has been growing at an average rate of approximately 12% per year. During times of economic distress, the need for mental health services typically rise dramatically.

- A large number of the CMHC clientele are chronic patients who require ongoing care and treatment. Traditionally, CMHCs have not developed programs for the chronic patient. Only recently, have centers been asked to serve this client. Growth in this type of service has been quite rapid over the past five years. Although CMHCs are not always providing totally adequate service to chronic patients, centers are seeing 90% of the chronically mentally ill seeking public service. Without CMHCs, many chronically mentally ill would hve no services available to them.

WHO USES IT?

- In 1983, Kansas CMHCs provided care to approximately 80,000 Kansas citizens. The number of patients has doubled over the past eight to ten years largely as a result of deinstitutionalization. During the period of 1969-1979, the state hospital average daily census declined by more than half. Many of these former hospital patients now rely on CMHCs for mental health services.

- By 1985, if present trends continue, CMHCs will be providing care for over 90,000 Kansas citizens.

- Of the total patients in the public sector having diagnoses of psychotic conditions (severely disabled), over 57% are being served by CMHCs.

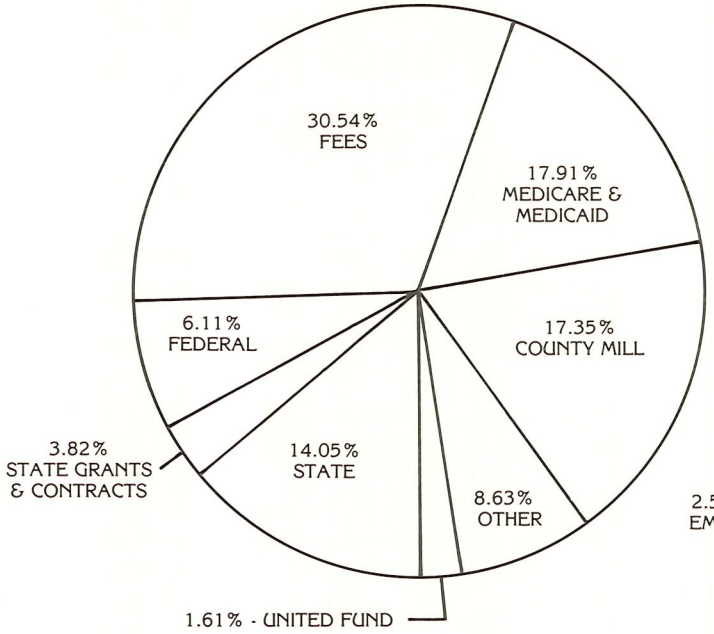
- In Kansas, 96.4% of all citizens seeking public mental health care are seen at community mental health centers.

- The major national and state change in mental health care over the last 15 to 20 years has been the shift from state institutional care to community based care.

HO PAYS FOR IT?

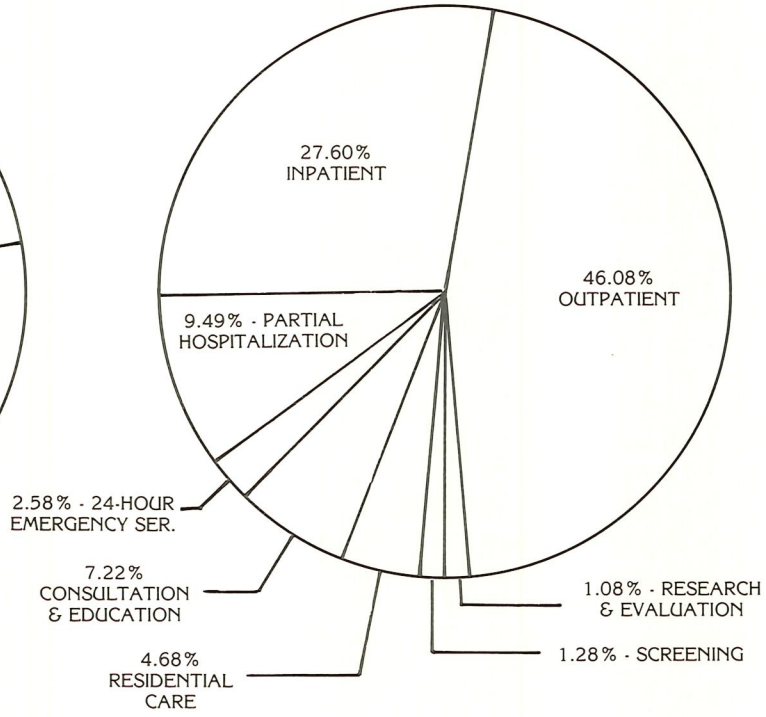
- No person, by law, can be denied community mental health care because of the inability to pay; consequently, public support is required.
- In 1983, county mill levies provided CMHCs with approximately $7 million. County funding is the single largest direct source of public support. Counties currently provide not only mill levy support, but other substantive funding as well. Mill levy support alone averages $3.54 per capita on a statewide basis.
- In FY 1984, direct state support for CMHCs is $5.6 million. Nationwide, the average state contribution to CMHCs as a percentage of total budget, is over 30%. In Kansas, about 13¢ of every CMHC dollar is provided by the state.
- The majority of CMHC costs were paid from community sources, with the largest share coming from the patient or his/her insurance provider.

CMHC REVENUE



1983 BUDGET ESTIMATE

CMHC EXPENDITURES



1983 BUDGET ESTIMATE

BUDGET NOTES

- "1983" Budget Year" means calendar year 1983.
- Some of the amounts do not reflect the 1983 Budget cuts, but do reflect what was appropriated by the 1982 Legislature.
- During calendar year 1983, CMHCs showed tremendous growth in the area of "partial hospitalization" programs. Total new expenditures for this category came too late to be included in this report. "Partial hospitalization" programs probably have the greatest potential to divert clients away from institutionalization.

#4- 2-29-84

Kansas Association of Alcohol and Drug Program Directors

February 29, 1984

To: Senate Public Health Committee Members

From: George Heckman, KAADPD

Re: Support for SB 781

The Kansas Association of Alcohol and Drug Program Directors represents more than forty-five agencies providing alcohol and drug abuse services in our state. The member agencies operate treatment, prevention and alcohol-drug safety action programs in a variety of settings across our state.

Our association strongly supports SB 781. This testimony is directed primarily at the alcohol and drug dependency coverage outlined in the bill. Each of you has received earlier information about the potential benefits and projected costs of providing mandatory insurance coverage for alcoholism and drug dependency which I will highlight.

A five year study by Holder and Hallen in California pointed out the following trends among the 337,000 members involved:

A) About ½ of 1% of the entire enrolled population used the alcoholism services each year.

B) The projected premium addition fluctuated from 9¢ to 19¢ per month per subscriber.

C) Outpatient care utilization increased over time.

In studying the families of alcoholics and matched non-alcoholic families, the following was discovered:

A) Total medical care costs for members in an alcoholic family (both inpatient and outpatient care) decreased substantially over time as the effect on the family of treatment of its alcoholic member occurred. ...At the end of the study, the inpatient cost per person per month of both the contract families and the alcoholic families were similar and the outpatient costs of the control families were actually higher.

Atch. 4

While most authorities agree that alcoholism and drug dependency are illnesses, concern will undoubtedly be expressed that alcoholism and drug dependency are self inflicted conditions. I would call your attention to present insurance coverage of maternity benefits. Health insurance groups have long been willing to finance maternity benefits, a self inflicted condition, which involves less than 1% of the insured population. It's time to overcome the stigma and ignorance surrounding alcohol and drug dependence and provide coverage for those who need it.

You're all aware of the tremendous cost alcoholism and drug dependency incurs upon our society. I don't need to go through this long list of problems and pain.

I might point out that there is division in the insurance industry about the cost of alcoholism coverage. Twenty states require insurance companies to cover alcoholism treatment costs and coverage has been provided quite economically. The New York State employer alcoholism benefit began in 1979 and now covers over 700,000 persons at a cost of under $2 per person per year during 1982. As of January 1, 1983, Blue Cross of Northeastern New York began providing coverage of alcoholism services to all its community-rated subscribers at no specific additional charge. The Kemper Insurance Company extended coverage in 1973 for non-hospital alcoholism treatment at no additional charge to its policyholders and continues to do so today.

In closing, a 1982 Gallup poll showed that 4 out of 5 Americans viewed alcohol abuse as a major national problem and 59% feel that alcoholism treatment should be covered by medical insurance the same as any other disease.

This bill effects too many Kansans to not get a vote by the entire Senate. We urge your support for SB 781.

#5 2-29-84

KANSAS PSYCHOLOGICAL ASSOCIATION

Central Office • 1112 W. 6th St., Suite 114 • Lawrence, Kansas 66044 • (913) 841-2425

TESTIMONY OF RICHARD B. MAXFIELD, Ph.D.
REGARDING SENATE BILL #781
February 29, 1984

I would like to thank the Chair and Committee members for the opportunity to give testimony on Senate Bill #781. I am Dr. Richard Maxfield. I am the President of the Kansas Psychological Association and a Certified Psychologist, primarily involved in direct patient care through the Adult Outpatient Department of the Menninger Foundation. I will restrict my comments to the cost effectiveness of providing mental health coverage under insurance programs and the expected economic impact of this legislation.

In recent years a body of literature has emerged in answer to the question: "Does providing mental health treatment reduce the utilization of covered medical-surgical procedures?" I should note from the outset that few, if any, patients seek mental health intervention to reduce their use of medical services. Nevertheless, there is a considerable body of scientific literature which suggests that there are cost offset benefits of providing mental health treatment. In a comprehensive review of the literature, Jones and Vischi found that mental health treatment had offset effects of reducing medical utilization in 24 out of 25 studies reviewed. The magniture of the reduction ranged from 5 to 80 percent. Although a number of those studies could be criticized if one uses rigorous scientific standards, the fact that all but one of the 25 studies reviewed found mental health treatments to substantially reduce medical costs strongly suggests that providing mental health coverage is fiscally sound. In the study cited by Jones and Vischi which is most relevant to Senate Bill #781, which looked at the

Atch 5

utilization rates of subscribers to Blue Cross of Western Pennsylvania over a four-year period, it was found that people who sought mental health services reduced their utilization of medical-surgical services from a pre-treatment average rate of $16.47 per month, to a post-treatment rate of $7.06 per month, a reduction of 57%. When the cost of the mental health treatment is included, the overall costs of all treatments declined from a pre-treatment rate of $20.40 per month to a post-treatment rate of $14.14 per month, a savings of 31%. It should be noted that 69% of the people treated in that study received fewer than eight psychotherapy sessions per year, which is roughly equivalent to the dollar limits of Senate Bill #781.

In a more recent study done by Schlesinger and others, it was found that people who had chronic physical diseases and who utilized mental health treatments had medical charges averaging $175 less per year over a four year period than those who did not have such mental health treatments. Further, the savings of decreased charges for medical intervention exceeded the costs of the mental health treatment within three years.

Many people have feared that the inclusion of mental health coverage in insurance programs will lead to over-utilization of mental health services for "self-actualization" or other non-essential services. Statistics from the Federal Emloyees' Health Benefit Program, which was one of the more generous packages of mental health coverage note that only two percent of their subscribers used their mental health benefits in 1977. Recently the Rand Corporation found that liberal mental health benefits were utilized by only nine percent of those covered and only five percent underwent psychotherapy. Thus, the fear that people will

flock to their psychiatrist's office if mental health treatments are covered by insurance is simply not supported by the available data. I would like to note that in my 15 years of practice I cannot recall ever seeing someone who sought treatment for anything other than serious difficulties. The decision to consult with a mental health professional most often occurs after family and other community resources have been exhausted.

Many people have feared that the availability of mental health coverage through mandates will drive up total costs, if not utilization rates. The economist Thomas McGuire reviewed the available data on the effects of mandates. He estimated that there is a net increase of use of resources of from one to two dollars per person per year which is attributable to a mandate. However, he noted that premiums may well increase more than that figure as costs are shifted either from existing users of service newly covered, or from state budgets. McGuire also noted that in 1979, Blue Cross and Blue Shield of Massachusetts, a mandated state, paid out slightly less than 30 million dollars per year for outpatient psychotherapy. Dividing that figure by the three million enrollees in the plan, one arrives at the estimate that including those mental health benefits would cost approximately $10 per person per year. An estimate which parallels Blue Cross and Blue Shield of Kansas' estimate that mandatorially including mental health coverage would lead to use of services to the tune of $8,659,700, an astoundingly high figure at first blush. However, when one divides that estimate by the total number of enrollees in the Blue Cross/Blue Shield plan, one arrives at more comprehensible figures. That is, Blue Cross and Blue Shield of Kansas estimate that the cost of legislation similar to Senate Bill #781 to be $12.37 per year per enrollee, or $1.03 per month, less than the price of a gallon of gas.

In summary, there is preliminary data which suggests that providing mental health coverage may be cost effective in that it may reduce the cost of other medical interventions. There is clear data that mandating mental health coverage will not lead to skyrocketing utilization or costs of such services. Further, there are additional potential benefits of mental health treatment to society which have not yet been well established in the literature. For instance, increased worker productivity, reduced absenteeism, and improved quality of life for patients treated and those who interact with them have been noted in some studies. To my way of thinking the likelihood that mental health treatment is cost effective is the secondary reason for mandating mental health coverage. The reduction of human suffering available to consumers through mental health treatment is ample enough reason to justify this proposed legislative mandate.

HG- 2-29-84

Statement Regarding House Bill No. 2795
Before the Insurance Committee of the Kansas House of Representatives

By: W. Walter Menninger, M.D.
13 February 1984

Thank you for the opportunity to comment on HB 2795. In speaking before you, I wear a number of hats - as a concerned citizen, as a psychiatrist who works with emotionally troubled persons, as a member of the professional Advisory Committee of the Mental Health Association, and as the Chairman of the Committee on the Chronically Mentally Ill of the American Psychiatric Association.

Those of us who work with the mentally ill are keenly aware of the reluctance of most people to acknowledge that they might have any kind of emotional illness. The stigma of admitting to oneself and to others that something is not working right in oneself mentally is hard to overcome. This stigma contributes to the reluctance of many people to face up to problems which they have and to get the kind of help that would best resolve the problems. The result is that many people with emotional problems either refuse to acknowledge them or instead experience some kind of physical distress which prompts them to seek help from a general physician. Studies have repeatedly demonstrated that a substantial proportion of patients who go to see primary care physicians - family physicians, internists, and the like - do not have anything physically wrong with them; rather, their complaints are a function of emotional problems played out in some physical complaint. This same stigma about mental illness limits people speaking out. It is for this

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reason that I feel obligated to speak out to you on their behalf. As much as we all tend to separate the mind from the body and operate as if there were no connection between the two, we disregard reality when we do so.

Although it is generally couched in terms of cost, I submit that the exclusion of coverage for mental illness is an extension and reinforcement of the stigma against mental illness. Somehow it is easier to deal with and acknowledge an obligation to pay for the diagnosis and treatment of a stomach ulcer or persistent problems with the bowels than it is to diagnose and treat the basic emotional problem which may underlie those symptoms - anxiety, depression, etc. - or emotional problems which do not have associated physical complaints.

I am keenly aware that the costs of all medical care have skyrocketed in recent years. It is understandable that earnest efforts have been made to contain some of the rising costs. It is, however, unconscionable that in the efforts to contain the costs there is an exclusion of coverage for mental illness. It is a myth that treating mental illness will break the bank when some appropriate limits are applied to that coverage. I will not attempt to repeat some of the information which I know you have heard or will hear from others about the cost factors and the comparison of the cost for mental health coverage versus the cost of physical coverage. I would draw attention to the fact that emotional illness remains an extremely costly problem for business and industry, reflected as it is not only in sick leave due to physical complaints which are based in emotional distress, but also in absenteeism, accidents and alcoholism. Enlightened executives will acknowledge that

investment in mental health care is a sound business investment and can generate greater productivity. Walter Wriston, Chief Executive Officer of Citicorp and Chairman of the Business Roundtable Task Force on Health, affirms this view: "There is a persuasive case to be made that providing effective prevention and treatment services is not only the right and humane thing to do, it is also a sound business investment.... When a manager sees absenteeism rising or coronary events increasing, he or she knows that it is not only a human problem, but a business challenge. Setting up mental health services to remedy these human problems and restore these employees to full productivity is a rational and legitimate business decision. The more sensitive such programs are to early detection, the better - for the employee, the company, and the whole society."

May I urge you to favorably endorse HB 2795 and refer it for passage.

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≠7-2-29-84

F.F.M.H.

Families For Mental Health, Inc.

JOHNSON COUNTY

P. O. Box 2452 Shawnee Mission, Kans. 66201

February 29, 1984

I am testifying today in favor of Senate Bill 781, as Past President of Families For Mental Health of Johnson County, and as a father of a 24 year old son who suffers from mental illness I am also representing 5 other Families For Mental Health groups in Kansas City, Wichita, Topeka, Newton and McPherson. All of these groups are made up of families who have family members suffering from mental illness and when a family member suffers the whole family suffers. Suffering is made up of the pain, frustration and anger in having a loved one who cannot function in society, and the problems involved in coping with this person and trying to find the services that can help our family member. Most of our families are not wealthy but are people who have struggled to gather together resources just to take care of their own daily lives, and don't have the extra resources to care for an ill family member from their own pockets. Insurance is not a luxury for these families--it is a necessity.

Our position is that mental illness is a legitimate illness, and it has a physical basis. Almost all the recent research into this area fortifies this position. Our position further is that, as a legitimate illness, mental illness should be insured on the same basis as the traditional physical illnesses, however, we are practical and know that this will not be accomplished overnight, therefore, we are proponents for Senate Bill 781, as a step in the right direction.

Our personal belief is that, if insurance were available, many people would get treatment earlier than they do now. This alone could result in less cost in the future both for mental and physical treatment. Our personal experience with this is that our son went through the agony of having his tonsils out at age 19 when it was not necessary, because he was looking for a solution to his mental problems. Had that same cost been applied to mental treatment, he might be a better functioning member of society today. This preventive treatment could well reduce the population of mentally ill people living on the streets. A population that is now estimated at 1 million people creating a situation which is fast becoming a national disaster.

Our families are not trying to feather our own nest in this matter. For those of us who had insurance benefits, they have run out long ago, and we now have no way of insuring a pre-existing condition. Our concern is with the future. With the persons who are unlucky enough to have mental illness and with the families who are unlucky enough to be directly involved. They could be your families.

Insurance is a method of spreading the risk of loss due to an unforeseen event. Mental illness is an unforeseen event. It causes great cost to all of those directly involved. That risk should be spread between everyone. The National Institute of Mental Health predicts that someone in 1/3 of all families will suffer some kind of mental illness. This is a large group of people to continue to ignore. It is time to recognize that this segment of our population has as much right to be insured as does the rest of the population.

It is an unfortunate fact that many people do not want to, or cannot psychologically accept the fact that they are at risk, therefore, when they select health insurance they ignore mental health coverage. The other fact is that when a person's employer selects the group coverage for the group the bottom line cost may be the predominent factor, and mental health coverage is not considered important. Therefore, until people become more mental health oriented it will be necessary to provide them with this coverage on a mandatory basis.

Howard W. Snyder

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Insurance for Mental Care

It's not hard to remember when a family with a mentally ill member lived in mortal fear "people would find out."

The matter was talked about in whispers. The person might be sent out of town. Upon his or her return, those who knew took care: It might be catching. As years passed, the next generation heard only snips of gossip, not enough to know if the secret was criminal, immorality, disease or some demonic combination.

Fortunately, all that has changed.

Emotional disease is generally accepted as a sickness as much as physical affliction, one that is treatable and deserving of compassion. Facilities for care have matured. Society has ceased to ostracize victims of mental illness and to blame them for having imaginary problems. Even the most skeptical individuals view therapy as an acceptable kind of help with personal nightmares.

At least, we are moving in those directions.

But vestiges of the old attitudes toward mental illness persist in insurance coverage in Missouri and Kansas. Companies don't have to provide such treatment as part of basic medical protection although it must be available as an option. A majority of those insured do not have it. This is a plain bit of discrimination against persons disabled by emotional pains. The distinction indicates those who write the rules figure the emotionally ill are kind of sick but not *really sick* such as someone felled by a heart attack.

Bills are now before the Kansas Legislature and the Missouri General Assembly to mandate insurance coverage for mental illness. The sponsors, Rep. Gary Blumenthal in Kansas and Rep. Carole Roper Park in Missouri, believe timely mental health care in the long run will reduce the total medical bill. The U.S. Public Health Service estimates at least 60 percent of all physician visits have an emotional rather than an organic basis.

Those and other pragmatic arguments are adequate reasons for supporting the measures, in addition to correcting the bias against mental disorders. Opponents' main objection is that it will cost more. That is a weak argument. Care for heart patients inflates insurance premiums. Yet no one has suggested isolating that group.

Families no longer exile emotionally troubled members. Now the insurance industry needs some updating.

The Sun Newspapers February 22, 1984—Page 3A

Editorial

Let's mandate the coverage

Remember when maternity benefits were not offered by all private companies, and many insurance companies did not include maternity benefits in their basic packages?

The government had to intervene and mandate maternity coverage.

That should make a strong case for the argument that you can't always leave it to the free market to work things out. In some circumstances, government intervention is a sound policy and is good for society.

I use that point to make another argument. Mental health insurance coverage should be provided in every company's benefit package and, more important, every insurance carrier should include benefits for inpatient and outpatient psychiatric expenses.

The Kansas Legislature will be considering a bill this week which will require insurance carriers to do just that. HB 2795 would mandate private insurance carriers to include inpatient and outpatient psychiatric and substance abuse treatment in their basic packages.

It's a national scandal that some insurance companies feel they can get away with eliminating mental health coverage, and a great many private companies have taken the easy way out by not paying the extra charge for the coverage as an option. It shouldn't be an option.

An individual suffering from emotional problems, depression, or paralyzing anxiety should be entitled to visit their family physician or psychiatrist without fear of having to pay 100 percent of the treatment.

Stephen F. Rose

Co-Publisher

Mental illness is just as real to the sufferer as a broken arm, and the pain is just as acute — if not more so. The therapy or medication prescribed is just as needed as the treatment for the common flu.

In an attempt to hold down insurance premiums for employers a great many insurance carriers have decided that mental health coverage is a quick and easy way to lop off costs. The protesting clamor from the public has been limited, partly because many are embarrassed to step forward to admit there might be a mental health problem in the family.

The bill before the Kansas House, introduced by a Johnson County State Representative, Gary Blumenthal (D), would mandate coverage for persons requiring treatment for alcoholism, drug abuse or nervous or mental conditions "limited to not less than 100% of the first $100 and 80% of the next $500 in any year" when a person can be treated with outpatient care. Hospitalization coverage, under this bill, would include reimbursement for "not less than 30 days per year."

This mandated mental health coverage will not break the insurance companies, would only minimally increase insurance premiums for employers, and would be a giant step forward in recognizing that the mental and emotionally ill are entitled to insurance coverage under basic health programs.

#8-2-29-84

Drug and Alcoholism Council

of Johnson County

5311 Johnson Drive Shawnee Mission, Kansas 66205 913-432-8424

TO : Members of the Senate Public Health & Welfare Committee

FROM: Ron Mersch, Legislative Chairman
Drug and Alcoholism Council of Johnson County

DATE: Wednesday, February 29, 1984

RE : SB 781

The Drug and Alcoholism Council is a citizen volunteer organization that conducts planning and community education on substance abuse issues for Johnson County. We annually conduct a review of substance abuse services available in the county. Each year the need for affordable treatment for persons without insurance or other means of private payment is identified.

Passage of SB 781 will enable more people to receive needed treatment through the increased availability of adequate insurance coverage. The average cost for a 21 - 30 day inpatient alcohol and drug treatment program is $5,000 - $5,500. Mandatory insurance coverage is a measure that will have its greatest impact on the middle income/working class population. These are the people who have jobs, have insurance, but simply do not have the personal financial resources necessary to obtain treatment.

The need for appropriate insurance coverage was evidenced in the results of a public opinion survey conducted by the Drug and Alcoholism Council at Oak Park Mall during a two-day drug and alcohol awareness fair in October, 1983. One hundred thirty-four respondents were asked if they were in favor of guidelines compelling insurance companies to cover drug and alcohol treatment.

A special project of United Community Services of Johnson County

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Sixty-four percent responded positively, 11% negatively and 25% were not sure. Survey respondents were from all age groups, family situations, and lived in Johnson County and surrounding communities.

While mandated insurance coverage for substance abuse treatment is not a total solution to the problem, it is a necessary component. With proper coverage many persons wanting treatment, but who could otherwise not afford it, will be able to seek help.

Thank you for your consideration of this very important issue.

#9- 2-29-84

Testimony S.B. 781

February 29, 1984 **Gene Johnson**

Madam Chairman, and members of the committee, I am Gene Johnson representing the 27 Kansas Community Alcohol Safety Action Projects Coordinators Association. We serve all of the 31 Judicial Districts in the State of Kansas for the evaluation of all DWI offenders.

During the 1982 Legislative session, a more severe DWI law was passed. One of the main thrusts of the change in our DWI laws was to place the financial responsibility on the offender rather than the taxpayers in general. Part of that legislation also mandated either alcohol and drug information/education school or alcoholism or drug addiction treatment for the first time offender. For those repeat offenders who have been convicted of DWI during the previous five years, the offender must serve a minimum of five days in jail, and then he can be paroled at the direction of the court to an alcohol/drug treatment program. In addition, the offender's driving privileges are suspended until he completes that court ordered treatment program to the court's satisfaction.

A majority of the DWI offenders have some type of hospital-medical insurance. However, many of the existing policies exclude the treatment of alcoholism or drug addiction. Our organization feels that an insurer which offers coverage for accident and sickness should cover a disease which has been recognized for over thirty years by our foremost health organizations. That disease being alcoholism. Many reputable treatment centers are "free standing" and not affiliated with any hospital or medical center. Other treatment centers offer "first class" out-patient treatment for those who are afflicked with alcoholism. These centers have to rely on private pay or

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public funds in order to maintain their programs. Third party pay would allow these programs to offer better and more complete treatment.

We support S.B. 781 as a positive step forward in the treatment of the disease of alcoholism and drug addiction. We also feel that this proposed legislation will lend support to the ongoing campaign against the drinking/driving offender. Our hope is that this committee will pass this proposed legislation favorably to combat what the former U.S. Representative Wilbur Mills stated recently as the "nation's biggest problem."

Thank you.

Gene Johnson

Gene Johnson

Kansas Community ASAP Coordinators Association

A10- 2-29-84

SENATE BILL 781
ESTIMATES COSTS

Estimated annual costs to add outpatient Psychiatric Rider ($1,000 Maximum Per Year; $15,000 Lifetime Maximum) to Kansas Blue Cross and Blue Shield Contracts currently without coverage and to increase the benefits for those Contracts with lesser outpatient psychiatric benefits:

Category	Estimated Monthly Rates		Estimated Additional Annual Costs
	Single	Family	
Farm	$3.58	$5.80	$ 643,900
Community Group	3.58	5.80	2,087,000
Merit Rated Group	2.80	4.67	3,079,000
State Employee Group	2.80	4.67	401,900
Total			$ 6,211,800

NOTE: In order to offer this coverage to Non-Group and Plan 65 subscribers on an individual selection basis, it would be necessary to impose restrictions such as waiting periods for as long as twelve months and to increase the subscriber's share of cost in the coinsurance. Without such limitations, the rates would reflect a minimal spread of risk and would approach the actual costs for each subscriber utilizing the coverage.

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#10 - 2-29-84

SENATE BILL 781
ESTIMATES COSTS

Estimated annual costs to add outpatient Psychiatric Rider ($1,000 Maximum Per Year; $15,000 Lifetime Maximum) to Kansas Blue Cross and Blue Shield Contracts currently without coverage and to increase the benefits for those Contracts with lesser outpatient psychiatric benefits:

Category	Estimated Monthly Rates		Estimated Additional Annual Costs
	Single	Family	
Farm	$3.58	$5.80	$ 643,900
Non-Group	3.58	5.80	351,700
Plan 65	3.58	5.80	6,848,000
Community Group	3.58	5.80	2,087,000
Merit Rated Group	2.80	4.67	3,079,000
State Employee Group	2.80	4.67	401,900
Total			$13,411,500

NOTE: The above rates and annual costs assume benefits would be mandated for all Contracts.

#11 - 2-29-84

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Testimony before the

Senate Public Health & Welfare Committee

re: S.B. 781

February 29, 1984

Good morning, members of the Committee and others. My name is David Burk, member of the Board of Directors of the Kansas Employer Coalition on Health. The Board and general membership of KECH want to thank you for having us speak before you today on mandating coverage for alcoholism, drug abuse, and nervous and mental conditions. Before addressing the proposal, I will briefly describe KECH and its mission.

KECH is a non-profit membership organization of employers throughout the state, formed early in 1983, whose focus is on the cost, quality, efficiency and effectiveness of the health care system in Kansas. It seeks to improve the system on those criteria and is especially concerned about the health care cost increases experienced by its member employers in recent years. Membership is open to all types of employers, including providers and insurors, in the belief that the problem: has built up over a long period, has been contributed to by all parties concerned, and will require the efforts of all parties to generate long term solutions.

There are currently 62 employer members of KECH, representing about 17,000 full time equivalent employees and thousands more dependents and retirees. The membership originates from throughout the state including Atchison, Kansas City, Topeka, Salina, Great Bend, Wichita, Coffeyville, Lenexa, Parsons and Pittsburg among other cities. A current brochure including members is attached. KECH is

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governed by a 13-member Board of Directors, whose chairman is Bill Woellhof, Vice President for Administration of Kansas Power & Light Company here in Topeka. Other organizations on the Board include:

Allis Chalmers Corporation
Lawrence Paper Company
Stauffer Communications, Inc.
Acme Foundry, Inc.
Blue Cross & Blue Shield of Kansas
Exline, Inc.
Fuller Brush Company
Goodyear Tire & Rubber Company
Kansas Medical Society
Security Benefit Group, Inc.
Stormont Vail Regional Medical Center

For any employer and for KECH, a cost containment strategy includes a multitude of possible actions toward three strategic objectives:

- Reducing consumer demand
- Creating efficiency incentives
- Controlling resource supply

Taken together, these objectives should begin to slow the growth in resources pouring into the health care system. Further, all the objectives must be pursued simultaneously in order for meaningful long term solutions to be achieved.

We will keep our comments brief and maintain that the bill under consideration runs counter to all the strategic objectives just mentioned.

Before presenting some points of concern to coalition members, let me first describe how KECH arrived at the position presented here.

All our members were polled about the legislation, and asked what position if any KECH should take. Only one of our responding members supported this legislation. Some of those who oppose do so, despite already offering similar coverage to their employees, because of a philosophical commitment to choice rather than government mandates. Others oppose it for the extra costs it would generate and the many facilities that could be reimbursed with less than optimal controls.

- o Roemer's Law, documented first with regard to hospital beds, is the common sense notion that if something is paid for by someone else ("free"), more demand will be generated for the service. This is especially true for health services because the doctor (or other professional) still knows best; providers can create their own demand. For example, throughout the country where you have more surgeons, you have many more surgeries for no apparent health reason. Patients are more likely to accept a professional recommendation to use a service if it is "free." In other words, mandating outpatient benefits will increase total expenditures, contrary to the cost containment goal of reducing consumer demand.
- o We are seeing employers and government policymakers argue that consumers should share in the cost of services to become "price sensitive." This will decrease demand. The RAND Institute study published early this year (copy attached) found that those consumers who shared more in the cost did indeed use up to 1/3 fewer services with no decrease in health, including mental health which was measured separately. This bill runs counter to such competitive efforts to contain costs reinforcing the old cost based reimbursement system that caused much of our health cost problem.
- o One means to generate efficiency is professional review of services used to assure they are medically necessary. Unfortunately, mental health services are difficult to review effectively since there is often disagreement about diagnosis and appropriate treatment. Therefore, the amount of services used cannot be readily controlled and is often related to the amount that will be reimbursed.

- o The argument is often presented that outpatient coverage will avoid costly inpatient coverage in the future. However, there is no data available documenting the number of hospitalizations that would be saved by outpatient coverage. In fact, this legislation would add over $25/yr. to a subscriber's premiums, with no choice as to whether that coverage should be included in their group plan. And Kansas employers already spend $750,000,000 on health insurance premiums for their employees!
- o Large employers (over 400 or 500 employees) will increasingly self-insure their plans to avoid these state requirements which will also cost the state premium tax dollars. Those most affected will then be the small employers in Kansas, some of whom have dropped their insurance coverage in recent years due to the high cost.

  As you well know, small businesses represent the overwhelming block of employers in Kansas. Under this legislation employers will have to spend those dollars for these specific services taking away their choice as to how they would have spent those dollars. And government studies have shown that workers with a choice, after receiving basic coverage, prefer cash over more comprehensive health benefits.
- o Any long term cost containment strategy requires that the health system's growth at least be managed if not contained. The system is like a balloon which expands with more air. To add required services will expand the balloon unless equal air is removed through other means. Bills such as this one will <u>require</u> that additional dollars go into the system, precisely the opposite of what needs to be done to contain costs.

One of the long term strategies to contain health costs is to change unhealthy life styles by providing programs which will promote health. As part of the first

statewide employer health benefits survey, KECH is identifying how many firms are now or are considering providing health promotion programs. KECH supports employer involvement in health promotion programs for employees to reduce dependence on traditional mental health services. And as the attachments from a recent New York Times illustrate, different employers are providing various services to their employees.

The existing law giving employers the option to provide such coverage is consistent with the KECH goal of redesigning benefit packages to reflect true needs of employees. As employers, through KECH and their insurors get more detailed data on services used and needed by their employees, they can design their benefits packages to reflect real needs. This is preferable to being forced to include coverages that will increase demand but may not be the highest priority need for given groups of employees. KECH, on behalf of its employer members, therefore urges this Committee to reject this proposed bill.

Thank you for the opportunity to present these remarks. If there are any questions I will be pleased to try to respond.

SPECIAL ARTICLE

DOES FREE CARE IMPROVE ADULTS' HEALTH?

Results from a Randomized Controlled Trial

ROBERT H. BROOK, M.D., SC.D., JOHN E. WARE, JR., PH.D., WILLIAM H. ROGERS, PH.D., EMMETT B. KEELER, PH.D., ALLYSON R. DAVIES, PH.D., CATHY A. DONALD, M.A., GEORGE A. GOLDBERG, M.D., KATHLEEN N. LOHR, PH.D., PATRICIA C. MASTHAY, M.S., AND JOSEPH P. NEWHOUSE, PH.D.

Abstract Does free medical care lead to better health than insurance plans that require the patient to shoulder part of the cost? In an effort to answer this question, we studied 3958 people between the ages of 14 and 61 who were free of disability that precluded work and had been randomly assigned to a set of insurance plans for three or five years. One plan provided free care; the others required enrollees to pay a share of their medical bills. As previously reported, patients in the latter group made approximately one-third fewer visits to a physician and were hospitalized about one-third less often. For persons with poor vision and for low-income persons with high blood pressure, free care brought an improvement (vision better by 0.2 Snellen lines, diastolic blood pressure lower by 3 mm Hg); better control of blood pressure reduced the calculated risk of early death among those at high risk. For the average participant, as well as for subgroups differing in income and initial health status, no significant effects were detected on eight other measures of health status and health habits. Confidence intervals for these eight measures were sufficiently narrow to rule out all but a minimal influence, favorable or adverse, of free care for the average participant. For some measures of health in subgroups of the population, however, the broader confidence intervals make this conclusion less certain. (N Engl J Med 1983; 309:1426-34.)

SPENDING at least some money on medical care is indisputably worthwhile. But does spending yet more buy still better health? In individual cases, the answer may be an obvious yes or no, but in the population as a whole the point of diminishing (or absent) returns has been difficult to identify.[1-7]

Critics of the existing system have contended that developed countries spend too much on medicine; they argue that this practice increases iatrogenous illness.[8,9] The extreme versions of this argument, constituting a kind of "therapeutic nihilism," have been cogently criticized,[10,11] and in this country public policy has proceeded for more than five decades on the assumption that if some medical care is good, more would be better. The main instrument of this policy has been increased insurance coverage, both public and private.

While this policy has been in effect, the national outlay on medical care has steadily increased and has now reached a level that causes concern in many quarters. One of the few potential methods for reducing expenditure appears to be to increase the proportion of costs borne by the people who are consuming medical care.

What fraction of their costs, if any, patients should be required to pay is thus a central and serious question of policy. Proponents of cost-sharing argue that it curtails frank abuse and restrains the purchase of care that yields little or no benefit. Opponents counter that if people must pay out of pocket for medical care, their access to appropriate levels of care will decrease and they will suffer accordingly. Data in support of either position have been all but nonexistent.

This dearth of information prompted the federal government to support a controlled trial. Known as the Rand Health Insurance Experiment, the project randomly assigned a sample of families to a variety of different insurance plans; one group received all their medical care free of charge; others paid some percentage of their health bills up to a stipulated maximum. We have already reported that when cost sharing was higher, use of medical care (visits to physicians, adult hospitalizations) and accordingly total expenditures were lower.[12] To take one example, people enrolled in cost-sharing plans made only about two thirds as many outpatient visits as those receiving free care.[13]

These earlier analyses left an important question unanswered: Were the people who received free medical care, and who thus used more of it, healthier as a result? Here we report what happened to several health-status measures among a group of adults under age 65 who received free care, as compared with a similar group that was required to share in the cost of care.

METHODS

Sample and Sites

The experiment, which ran from November 1974 through January 1982, enrolled 3958 people between the ages of 14 and 61 who belonged to 2005 families; 70 per cent of the sample participated for three years, and the remainder for five years. Families lived in one of six sites (Seattle, Washington; Dayton, Ohio; Fitchburg or Franklin County, Massachusetts; and Charleston or Georgetown County, South Carolina) and, except for certain intentional differences, were

From the Departments of Medicine and Public Health, Center for the Health Sciences, University of California at Los Angeles, and the Departments of Economics, Behavioral Sciences, and System Sciences, The Rand Corporation, Santa Monica, Calif., and Washington, D.C. Address reprint requests to Dr. Brook at The Rand Corporation, 1700 Main St., Santa Monica, CA 90406.

Supported by a Health Insurance Study grant (016B80) from the Department of Health and Human Services, Washington, D.C. The views expressed are those of the authors and do not necessarily represent those of the Department of Health and Human Services or of The Rand Corporation.

representative of the general population of the area where they lived.[12,14,15]

Excluded from the experiment were families with an annual income above $54,000 (1982 value), who constituted about 3 per cent of those initially contacted; persons who were too badly disabled to work and therefore eligible for Medicare; and family members over the age of 61 at entry to the study. Included in the overall experiment but not in this analysis (nor in the above numbers) were children under the age of 14 and a group of families in a prepaid group practice; they are the subjects of separate analyses.

Insurance Plans and Benefits

Families were assigned to one of 14 experimental insurance plans by a random-sampling technique that made the distribution of family characteristics in each as similar as possible.[16] No premium was charged for any plan. Any family assigned to a plan that offered less coverage than its current insurance was reimbursed an amount equal to its maximal possible loss. This money was paid in installments every four weeks, and the family was not required to spend it on health care. Such payments had a negligible effect on use.[15]

All plans covered ambulatory and hospital care, preventive services, most dental services, psychiatric and psychological services (limited to 52 visits a year), and prescription drugs.[12]

For this analysis, each of the 14 insurance plans was assigned to one of four categories (one providing free care, the other three requiring cost sharing) as follows: the free plan, under which the family received all services without charge; the individual-deductible plan, under which the family paid 95 per cent of the cost of each outpatient service up to an annual out-of-pocket expenditure of $150 for each person ($450 for a family), and all outpatient care beyond that amount, as well as all inpatient care, was free; the nine intermediate coinsurance plans, under which the family paid 25 or 50 per cent of all its health bills each year, inpatient and outpatient, until it had spent 5, 10, or 15 per cent of its income or $1,000, whichever was less (in three of these nine plans the family paid 50 per cent for dental and mental-health services and 25 per cent for all other services; in some sites and years the maximum expenditure was limited to $750); and finally the three income-related catastrophic plans, under which the family paid for 95 per cent of all its health bills up to 5, 10, or 15 per cent of its income or $1,000, whichever was less.

In many analyses we have grouped the cost-sharing plans and compared them with the free-care plan.

Health-Status Variables

Starting with the World Health Organizations's definition of health,[17] we developed or adapted measures to evaluate the effect of cost-sharing on health status. This comprehensive set comprised four distinct categories — general health, health habits, physiologic health, and the risk of dying from any cause related to risk factors (i.e., high blood pressure, high serum cholesterol level, or cigarette smoking). Because actual deaths in our experimental population

Table 1. Operational Definitions and Mean Scores for Self-Assessed General Health Measures at Enrollment.

Health Variable and Operational Definition	Typical Item	Mean Score at Enrollment		Interpretation of Effect Size
		"Good" Health *	"Ill" Health †	
Physical functioning: A standardized (0–100) scale (23 items) that indicates the degree to which the person has limitations in personal self-care, mobility, or physical activities.[19,20] A high score means greater capacity for physical activity.	"Do you have any trouble either walking one block or climbing one flight of stairs because of your health?"	100	44.8	A 10-point difference = the effect of having chronic, mild osteoarthritis. ‡§
Role functioning: A dichotomous measure (2 items) that indicates whether the person can perform work, school, or housework activities free of limitations due to poor health.[19,20] A high score means a higher probability of role functioning. Mean probabilities are expressed as percentages.	"Does your health keep you from working at a job, doing work around the house, or going to school?"	100	0	A 1-point difference = a probability 1 percentage point higher of being limited in the performance of one's principal role.
Mental health: A standardized (0–100) scale (38 items) that measures anxiety, depression, emotional ties, behavioral/emotional control, and psychological well-being during the previous month.[21-23] A high score reflects higher or more positive levels of mental health.	"How much of the time, during the past month, have you felt downhearted and blue?"	86.4	53.0	A 3-point difference = the impact of being fired or laid off from a job.
Social contacts: A standardized (0–100) scale (3 items) that measures contacts with friends and relatives during the past month or year.[24] A high score reflects higher levels of social activity.	"About how often have you visited with friends at their homes during the past month? (Do not count relatives.)"	94.3	29.1	A 10-point difference = an increase of 2 percentage points in the probability of being psychiatrically impaired.
Health perceptions: A standardized (0–100) scale (22 items) that measures the person's perceptions of past, present, and future health, susceptibility to illness, and worry about health.[25] A high score reflects better perceptions of one's health status.	"My health is excellent."	83.6	47.8	A 5-point difference = the effect of having been diagnosed as having hypertension. ¶

*Mean scores for the healthiest 40 per cent of the distribution.

†Mean scores for the sickest 20 per cent of the distribution.

‡Among participants in the experiment, adjusted for age and sex.

§Classification is based on the person's responding yes to questions about ever having acute or chronic pain, aching, swelling, or stiffness in fingers, hip, or knee.

¶Classification is based on the person's responding yes to a question about ever having been diagnosed as having high blood pressure and yes to a question about having been so diagnosed more than once or to a question about having had pills or medicines prescribed for high blood pressure.

Table 2. Operational Definitions and Mean Values for Health Habits and Physiologic Measures.

Health Variable and Operational Definition	Mean Value for Persons at Elevated Risk *	Specific Scoring
Smoking: A six-level measure of the risk of death due to smoking relative to not smoking.[26]	1.89	Never smoked/exsmoker 1.00 Pipe/cigar smoker only 1.06 Cigarette smoker <1 pack/day 1.57 1 pack/day 1.79 2 packs/day 2.07 >2 packs/day 2.20
Weight (kg) †	88.4	Standardized for height (in meters) by multiplying by $(1.75/\text{height})^2$ for men and by $(1.65/\text{height})^{1.5}$ for women. Standardized for sex by summing 0.5 (average value for men) and 0.5 (average value for women).[27]
Serum cholesterol level (mg/dl)	242	
Diastolic blood pressure (mm Hg)	88	
Functional far vision: Measured in no. of Snellen lines. "Functional" means with whatever correction (if any) used by the person to improve vision.	2.95 ‡	Line 2 = 20/20 Line 3 = 20/25 Line 4 = 20/30
Risk of dying: The risk of dying from any cause relative to that of persons with average values of major risk factors: 100 exp(Index)/(1 + exp(Index)), where Index = 1.28 smoking scale + 0.0023 cholesterol + 0.023 systolic blood pressure − 9.52.	2.02	The coefficients of the risk factors are median values of the coefficients in the logistic regressions for death from any cause in five studies of heart disease in middle-aged men.[28]

*Means for the sickest 25 per cent of the distribution except for functional far vision. Enrollment values are given for smoking and weight. Predicted exit values are given for cholesterol level, blood pressure, vision, and risk of dying.

†Values exclude those for persons 14 to 17 years of age at enrollment and pregnant women.

‡Value represents the mean corrected score for vision of those whose uncorrected vision in the better eye was worse than 20/20; i.e., the mean for the worst 53 per cent of the distribution.

were too infrequent to allow meaningful analysis, we calculated an index predicting the extent to which eventual mortality would be affected by the specified risk factors.[18] In this paper we analyze 11 measures from the four categories (Tables 1 and 2). A number of other physiologic measures, as well as measures of dental health, have yet to be examined.

Data on general health (such as physical health, role functioning, and health perceptions) and health habits (such as smoking) were collected from a medical-history questionnaire that was self-administered at the beginning of the experiment (enrollment) and three or five years later (exit); the reliability, validity, and other psychometric properties of these measures have been reported elsewhere.[19-27,29] Blood pressure, serum cholesterol level, and visual acuity were measured at medical screening examinations that were given at enrollment to a randomly selected 60 per cent of the sample and at exit to the entire sample.[30-32]

Methods of Analysis

To answer the question "Did the free plan improve health more than the cost-sharing plans?" we began by identifying certain variables that could be expected to affect the results and could be used in developing health-care policy. We then employed regression methods to estimate the influence of the "explanatory" variables (such as cost of care under each plan, family income adjusted for size and composition of the family, and initial state of health) on the "response" variable — namely, health status at exit.[28]

To interpret these effects we then used the regression equations to predict the health status at exit of people with any given set of characteristics at entry. In particular, we calculated health status for the average participant and for those in certain subgroups with relatively high or low incomes and with good or poor health.

Because we especially wanted to know the effect of cost sharing on people with poor health or low income, we measured all interactions between these factors and the various insurance plans. A score on each of the five general-health measures was determined for a person who was initially "ill" or in "good health." Being "ill" was defined as being in the lowest fifth of the distribution of health status at enrollment, being in "good health" as being in the highest two fifths (Table 1). The effect of "low" or "high" income at enrollment was also tested. A "low" income was one in the lowest one fifth (a mean of $7,300 for a family of four in 1982 dollars), a "high" income was one in the highest two fifths (a mean of $40,000). For all the remaining explanatory variables, we used mean population values in the regressions when generating the predictions.

Medical care could be expected to have the most benefit for people with a health problem, but plan effects might be obscured if data on this subsample were pooled with those on the whole group. Accordingly, for each indicator of physiologic health (blood pressure, vision), health habits (smoking, weight, and cholesterol level), or risk of dying (Table 2), we divided our sample into those likely, by the time of exit, to have abnormal or normal values on the basis of data from the initial examination and responses to the questionnaire. We could detect no significant effects of the insurance plan on values for the group that was expected to have normal values at exit, so we focused the analysis on the group that was expected to be least healthy or at an elevated risk of dying (the least healthy quarter of the sample). For visual problems, we defined persons at high risk as those with an acuity at exit that was worse than 20/20 in the better eye without glasses (roughly half the sample).

Because we had no prior expectation that cost sharing would affect health either favorably or adversely, we used two-tailed tests of significance throughout. We have followed the convention of labeling a result "significant" if it was likely to occur by chance no more often than 1 time in 20. However, results falling short of this criterion should not necessarily be ignored. In some cases, although the calculated result is statistically insignificant, the confidence interval indicates that its actual value could plausibly have some clinical importance; that is, the range of values having 95 per cent certainty of bracketing the real one could include some that are medically important. All statistical tests were corrected for correlation of the error term within each family and for the nonconstant variance of the error term.[28,33]

Possible Artifacts and Biases

We anticipated three problems that may have led to biased estimates or erroneous inferences. First of all, the various plan offerings may have been accepted by different kinds of people, whose health or other characteristics would have biased the outcome. Secondly, participants may have dropped out of the various plans at different rates as a function of their current health. Either factor could have distorted our picture of the actual effects of being enrolled in a particular plan. Thirdly, certain data were missing: some gaps were "unplanned" (for example, participants occasionally did not complete all questions on the exit questionnaire), and some were "planned" (certain participants, for example, were not asked to take an enrollment screening examination). Only the unplanned loss of data carried the potential for bias, because the planned gaps were known to have been distributed randomly.

We adopted several strategies to counter the potential for bias. First of all, we compared health-status values at enrollment for participants in each plan, and we compared selected characteristics of the people who refused the offer with those of the people who accepted. If these groups had similar values, we would have little reason to suspect bias.

Secondly, in the regression models we included initial values of the health-status variables as well as values of other variables

known to influence the response under study. (For example, high blood pressure at entry predicted high blood pressure at exit.) We thereby controlled statistically for any effect of nonrandom composition of the sample with respect to these explanatory variables.

Thirdly, through questionnaires we obtained longitudinal information on general health measures and smoking for people who voluntarily withdrew from the experiment and for those who did not complete the experiment for other reasons. Thus, we were able to include many of the dropouts in the analysis. We did not attempt to recover information on physiologic measures from participants who left the sample prematurely; results for these measures were based only on values for those who completed the experiment.

Data missing as a result of unplanned nonresponse never amounted to more than 2 per cent for any one question, so bias from this source should have been negligible. Nevertheless, in order to include people with missing data in the analysis, we imputed scores to them.[28,34]

Results

Threats to Validity

Acceptance of the Enrollment Offer

Acceptance rates varied as a function of plan: 92 per cent of the families accepted the offer to join the free plan, 83 per cent the individual-deductible plan, 89 per cent the intermediate plans, and 75 per cent the catastrophic plans. To determine whether these different acceptance rates may have biased our results, we examined the health status of all enrollees at the start of the experiment and detected no significant differences among plans in any health measure at enrollment or in family income, education, or age (Table 3). Only the proportion of female family members was slightly different according to plan, and one significant difference would be expected to occur by chance among the 20 comparisons made.

We also compared people who refused the enrollment offer with those who accepted.[28] Results of this comparison established that the different acceptance rates were unlikely to have affected our conclusions.

Retention in the Experiment

During the experiment, each plan lost some of its participants because of voluntary withdrawal (including withdrawal to join the military), involuntary factors (such as

Table 3. Values of Demographic, Study, and Health-Status Measures at Enrollment, According to Type of Experimental Insurance Plan.*

Variable and Brief Description †	Cost-Sharing Plans				Free Plan	T-Test Value ¶
	Catastrophic	Intermediate	Individual Deductible	Total ‡		
No. of enrollees ≥14 years of age	759	1024	881	2664	1294	
Mean age (yr)	32.8	33.8	33.6	33.4	33.3	−0.0
Sex (% female)	56.1	53.5	53.8	54.4	52.2	−2.1
Race (% nonwhite)	20.8	17.4	18.3	18.9	16.6	−1.2
Mean family income adjusted for family size (1982 dollars) §	21,500	22,800	23,300	22,500	22,100	−0.5
% Hospitalized in year before enrollment	11.5	11.2	12.0	11.6	11.7	0.1
Mean no. of physician visits in year before enrollment	4.49	4.23	4.80	4.51	4.55	0.2
Mean education (yr)	11.9	12.0	12.0	12.0	11.8	−1.4
% Taking enrollment screening examination	59.1	57.8	58.6	58.5	62.5	1.6
% Enrolled for 3 years	69.8	67.4	71.3	69.5	68.9	−0.3
Physical functioning (mean score, 0–100)						
Enrollees	89.6	88.7	89.1	89.1	88.9	−0.2
Analytic sample	89.6	89.0	89.6	89.4	89.0	−0.5
Role functioning (mean score, %)						
Enrollees	94.8	91.9	91.8	92.8	93.1	0.3
Analytic sample	94.8	92.1	92.5	93.1	93.0	−0.2
Mental health (mean score, 0–100)						
Enrollees	73.8	75.0	73.7	74.2	74.7	0.9
Analytic sample	73.8	75.1	73.9	74.3	74.7	0.8
Social contacts (mean score, 0–100)						
Enrollees	72.8	72.1	72.3	72.4	72.5	0.1
Analytic sample	72.6	72.2	72.0	72.2	72.5	0.3
Health perceptions (mean score, 0–100)						
Enrollees	70.5	71.1	69.4	70.4	69.7	−1.2
Analytic sample	70.4	71.2	69.7	70.4	69.8	−1.2
Smoking scale (mean score, 1–2.20)						
Enrollees	1.29	1.30	1.32	1.30	1.29	−0.7
Analytic sample	1.28	1.29	1.30	1.29	1.29	−0.3
Mean standardized weight (kg)						
Enrollees	71.5	71.3	71.0	71.3	71.3	0.0
Analytic sample	71.6	71.3	71.6	71.5	71.6	0.2
Mean cholesterol level (mg/dl)						
Enrollees	207	205	206	206	202	−1.9
Analytic sample	208	205	207	207	204	−1.5
Mean diastolic blood pressure (mm Hg)						
Enrollees	75.2	75.3	75.4	75.3	74.6	−1.4
Analytic sample	76.0	75.4	75.7	75.7	74.7	−1.9
Functional far vision (mean no. of lines)						
Enrollees	2.28	2.39	2.42	2.37	2.33	−0.9
Analytic sample	2.28	2.37	2.41	2.35	2.32	−0.9
Risk of dying (mean score)						
Enrollees	0.99	1.04	1.13	1.05	1.03	−0.6
Analytic sample	0.99	1.06	1.13	1.06	1.03	−0.8

*Values are adjusted for differences according to site.

†For demographic data, table entries include everyone with valid enrollment data. For health measures, the mean score for enrollees excludes persons who did not have valid enrollment data because of the study design (e.g., they were not assigned to an initial screening examination) or to missing data, and the mean score for analytic samples excludes the same persons plus those who did not have valid exit data.

‡Values represent equally weighted averages of the three types of cost-sharing plans.

§For an explanation and rationale of the adjustment, see Brook et al.[28]

¶Value shown is for the difference between free and cost-sharing plans.

Table 4. Numbers of Adult Enrollees According to Category of Participation in Experiment and Plan.

Category of Participation	Cost-Sharing Plans								Free Plan		Total	
	Catastrophic		Intermediate		Individual Deductible		Total					
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Total enrolled	759	100.0	1024	100.0	881	100.0	2664	100.0	1294	100.0	3958	100.0
Completed enrollment and exited normally	642	84.6	926	90.4	772	87.6	2340	87.8	1225	94.7	3565 *	90.1
Left experiment voluntarily	83	10.9	43	4.2	53	6.0	179	6.7	5	0.4	184	4.7
Terminated for health reasons †	3	0.4	13	1.3	11	1.3	27	1.0	15	1.2	42	1.1
Terminated for non-health reasons †	24	3.2	31	3.0	34	3.9	89	3.3	38	2.9	127	3.2
Died	7	0.9	11	1.1	11	1.3	29	1.1	11	0.9	40	1.0
Recovered for analysis ‡	94	80.3 §	84	85.7	69	63.3	247	76.2	54	78.3	301	76.6

*The actual analyses are based on a slightly smaller sample, because forms were not available for under 1 per cent of this sample.

†Participation ended because the person no longer fulfilled criteria for participation eligibility. Health reasons included becoming eligible for disability Medicare and being institutionalized; nonhealth reasons included joining the military and failure to complete data-collection forms.

‡Form nonresponse not included. The number analyzed equals the number completed plus the number recovered minus the number of nonresponses.

§Percentages in this row are based on the number of enrollees in each plan who did not complete enrollment.

incarceration), health reasons (mainly, becoming eligible for disability Medicare), or death. The latter two health-related factors did not differ materially as a function of plan (Table 4). In all, 95 per cent of those in the free plan completed the experiment normally by filling out the medical-history questionnaire and going through the final screening examination, as did 88 per cent of those in the individual-deductible plan, 90 per cent in the intermediate plans, and 85 per cent in the catastrophic plans.

To test whether these differences affected our results, we collected data on general health measures and smoking behavior of people who had terminated for various reasons and ran our analyses with and without them. Our findings were not altered by including or excluding these data, which were obtained from 73 per cent of those who withdrew voluntarily, 83 per cent of those who terminated for health reasons, 78 per cent of those who died, and 82 per cent of those who terminated for reasons not related to health. Thus, data from these people were included, and the final sample used for the questionnaire-based analyses comprised 99 per cent of the participants in the free and intermediate plans, 97 per cent of those in the catastrophic plan, and 95 per cent of those in the individual-deductible plan. The percentages with complete data on physiologic measures (as well as weight) were lower because after enrollment no screening examination was administered to the participants who left the experiment early.

As a further check for possible bias, we examined the values for health status at enrollment in the actual sample used for each analysis. We detected no differences according to plan (Table 3).

Effects on Health Status

Exit Values According to Plan

For the average person enrolled in the experiment, the only significant positive effect of free care ($P<0.05$) was that for corrected far vision, although the difference in diastolic blood pressure approached statistical significance ($P = 0.06$) (Table 5). The corrected vision of those enrolled in the free plan was better (2.4 vs. 2.5 Snellen lines, or an acuity of about 20/22 vs. 20/22.5).

No other health measure showed a significant difference between the free and the cost-sharing plans. Furthermore, only for hypertension, the risk of dying, and role functioning did the direction of the overall (main) effect favor the free plan (see the two rightmost columns of Table 5). For the remaining measures, the direction of the main effect favored the cost-sharing plans.

Confidence limits for the differences between the free and the other plans were relatively narrow in all cases; thus, it is unlikely that our conclusion that there was little or no effect is far off the mark. To verify that this conclusion did not depend on our method of prediction, we compared the predicted differences with the differences between the raw means of the two groups. The predicted differences and the differences in the raw means scarcely diverged (see the two rightmost columns of Table 5), although precision was better for the predicted values.

Within the cost-sharing group of plans, outcomes were more similar than between the free-care plan and the cost-sharing plans. Such an outcome is not surprising because differences in use were greater between the free-care plan and the cost-sharing plans than within the group of cost-sharing plans.[12]

The Influence of Income and Health Status on General Health

In addition to detecting no significant effect on five general measures of health for the average person (Table 5), we were unable to detect any significant differences among subgroups that differed in income and initial health status (Table 6). Confidence intervals for subgroup analyses were, of course, wider than for the sample as a whole; hence, we cannot be as

certain as with the entire sample that clinically important effects did not occur in these subgroups.

The Elevated-Risk Groups

At the end of the experiment, neither smoking status, cholesterol level, nor weight differed as a function of plan, even among participants judged to be at elevated risk on these measures (Table 7). Diastolic blood pressure among those who were hypertensive or nearly hypertensive was 1.4 mm Hg lower on the free plan than on the cost-sharing plans ($P = 0.07$). Among those whose uncorrected far vision was worse than 20/20, corrected vision was, collectively, about 0.2 Snellen lines better — an improvement in visual acuity from 20/25 to 20/24 ($P<0.05$).

For the average person at exit, the risk of dying from any cause (on the basis of smoking habits, cholesterol level, and systolic blood pressure) was set arbitrarily at 1.0. By comparison, the relative risk of dying for someone in the group at elevated risk (generally the upper quartile of the distribution of risk factors) was, on average, 2.02; that is, a member of this group would have been twice as likely to die during the subsequent year as the average person of the same age and sex. For high-risk members of the free-care plan at exit, the relative risk of dying was 1.90, as contrasted with 2.11 for those in the cost-sharing plans (Table 7). This 10 per cent difference in favor of free care was significant ($P<0.05$) and was principally attributable to the improved control of high blood pressure among those in the free plan.

The improvements in vision, blood pressure, and risk of dying were largest in the group with low income and elevated risk (see the first column of Table 8). For them, the differences between the free and the cost-sharing plans were significant for blood pressure and the risk of dying, whereas neither of these differences was significant for the higher-income group. For instance, the difference in diastolic blood pressure for persons of low income who were judged initially to be at increased risk of hypertension was 3.3 mm Hg ($P = 0.02$); for such persons of high income it was only 0.4 mm Hg ($P>0.05$).

At this point, it is tempting to infer that free care improved the health of the poor but not of the rich. Unfortunately, our data do not permit quite such a blunt summary. If we begin with the (null) hypothesis that free care makes no difference to the poor who are at elevated risk, our findings permit us to reject it; free care does make a difference, as shown by the two significant values in Table 8. On the other hand, we were unable to demonstrate that free care benefited people with a high income and high risk; here we cannot reject the null hypothesis. Given the conditions of our experiment, free care made no detectable difference to this group. Now, however, a paradox emerges. If we start with another null hypothesis — that the two income groups responded in the same way to the various plans — we would expect to see it rejected, but because the differences between the two groups are not significant, we cannot reject this hypothesis.

Thus, we are reasonably confident that poor people at elevated risk benefited from receiving free care, but we cannot draw any conclusion about the higher-income group. We cannot say that they benefited from receiving free care, but we also cannot show that they responded differently from the lower-income group, who were benefited.

Table 5. Predicted Exit Values of Health-Status Measures for an Average Person According to Measure and Plan, and Raw Mean Difference.

Health-Status Measures	No. *	Cost-Sharing Plans				Free Plan	Predicted Mean Difference (free minus cost-sharing) †	Raw Mean Difference (free minus cost-sharing)
		Catastrophic	Intermediate	Individual Deductible	Total			
General health (score, 1–100)								
Physical functioning	3862	86.0	85.0	84.9	85.3	85.3	0.0 (−1.6, 1.5)	−0.3 (−2.3, 1.7)
Role functioning	3861	95.5	95.0	94.7	95.1	95.4	0.3 (−0.6, 1.2)	−0.3 (−2.2, 1.6)
Mental health	3862	75.6	75.5	75.8	75.6	75.5	−0.2 (−1.1, 0.8)	−0.1 (−1.1, 1.0)
Social contacts	3827	69.3	70.2	69.8	69.8	69.4	−0.3 (−2.3, 1.6)	−0.2 (−2.4, 2.0)
Health perceptions	3843	68.1	68.0	67.9	68.0	67.4	−0.6 (−1.5, 0.3)	−0.9 (−2.1, 0.3)
Health habits								
Smoking (scale, 1–2.20)	3758	1.28	1.29	1.29	1.29	1.29	0.0 (−0.02, 0.02)	−0.00 (−0.03, 0.03)
Weight (kg)	2804	72.8	72.6	73.1	72.8	72.8	0 (−0.5, 0.5)	0.0 (−1.0, 1.0)
Cholesterol level (mg/dl)	3381	202	200	204	202	203	1.0 (−1, 3)	1 (−2, 4)
Physiologic health								
Diastolic blood pressure (mm Hg)	3232	79.2	79.1	79.3	79.2	78.5	−0.7 (−1.5, 0.02) ‡	−0.8 § (−1.7, −0.02)
Functional far vision (no. of Snellen lines)	3477	2.55	2.50	2.51	2.52	2.42	−0.1 (−0.16, −0.04) ¶	−0.13 (−0.20, −0.06)
Risk of dying (score)	3317	1.01	0.98	1.03	1.01	0.99	−0.02 (−0.05, 0.02)	−0.03 (−0.07, 0.02)

*Numbers of persons in various parts of the analysis are dissimilar because noncompleters were not included for physiologic health, weight, or cholesterol level and because of differences among measures in the number of persons with valid enrollment or exit data.

†Numbers in parentheses are 95 per cent confidence intervals; an approximate confidence interval is given for role functioning.

‡$t = 1.89$, $P = 0.06$.

§Although this value is significant, because of differences in base-line blood-pressure values, it cannot be relied on.

¶$t = 3.29$; $P = 0.001$. Persons with normal vision were included and given a value of 2.0.

Table 6. Predicted Exit Values of Self-Assessed General Health Measures According to Measure, Plan, Income, and Initial Health Status.*

General Health-Status Measure	Total Cost-Sharing	Free Plan	Free Minus Cost-Sharing †	Total Cost-Sharing	Free Plan	Free Minus Cost-Sharing †
	Low Income and Initial Ill Health			*Low Income and Initial Good Health*		
Physical functioning	60.3	65.9	5.6 (−2.9, 14.0)	89.8	91.2	1.4 (−1.6, 4.4)
Role functioning	69.0	46.3	−22.7 (−53.2, 7.8)	95.0	96.1	1.1 (−1.8, 4.0)
Mental health	65.6	67.0	1.4 (−1.8, 4.7)	81.1	79.3	−1.8 (−4.1, 0.6)
Social contacts	51.8	55.3	3.5 (−5.2, 12.2)	77.7	77.9	0.2 (−4.1, 4.5)
Health perceptions	54.2	54.6	0.3 (−3.0, 3.7)	74.7	72.4	−2.3 (−4.8, 0.1)
	High Income and Initial Ill Health			*High Income and Initial Good Health*		
Physical functioning	59.9	55.6	−4.3 (−9.8, 1.2)	92.6	91.9	−0.6 (−2.8, 1.6)
Role functioning	60.3	56.0	−4.3 (−24.1, 15.5)	96.3	96.3	0.0 (−2.0, 2.0)
Mental health	63.3	64.5	1.3 (−1.6, 4.1)	82.7	82.1	−0.6 (−1.9, 0.7)
Social contacts	47.3	47.6	−0.3 (−5.0, 5.5)	82.2	80.1	−2.1 (−5.1, 1.0)
Health perceptions	52.8	52.1	−0.7 (−3.1, 1.7)	77.7	77.8	0.1 (−1.4, 1.6)

*Initial health status is defined with respect to the individual health measure denoted in each row.

†Numbers in parentheses are 95 per cent confidence intervals; approximate confidence intervals are given for role functioning.

Discussion

One purpose of the Rand Health Insurance Experiment was to learn whether the direct cost of medical care, when borne by consumers, affects their health. Participants in the experiment received one of a graded set of insurance plans; for some, medical care was absolutely free, whereas for others the annual cost could range up to as much as 15 per cent of family income. The experiment was designed to be as "realistic" as possible. The sample was typical of a general population of adults with two major exceptions: it excluded severely disabled persons who were eligible for Medicare and those over age 61 at the start. Moreover, the study was conducted at sites representing a cross-section of American medicine; participants could, and did, choose their own physicians.

We found that the more people had to pay for medical care, the less of it they used. Adults who had to share the cost of care made about a third fewer ambulatory visits and were hospitalized about a third less often.[12] We might have expected that differences of this magnitude in their use of medical resources would have influenced the participants' health.

From our data we can draw three conclusions about what the influence was. We can, therefore, narrow the range of speculation about the relation between cost-sharing and health status.

First of all, free care had no effect on the major health habits that are associated with cardiovascular disease and some types of cancer. Enrollment in a more generous insurance plan, resulting in an average of one to two more encounters with a physician each year for several years, had no impact on smoking, weight (of either the average or the overweight), or cholesterol levels (average or elevated). Moreover, these habits, especially smoking, were at levels at which substantial health benefit from behavior change was possible.

Secondly, we detected no effects of free care for the average enrollee on any of five general self-assessed measures of health; and the confidence intervals in Table 5 rule out the possibility of anything beyond a minimal effect. We can be less certain of this interpretation of the findings with regard to subgroups differing in income or initial state of health, because the smaller samples yield wider confidence intervals (Table 6).

Thirdly, people with specific conditions that physicians have been trained to diagnose and treat (myopia, hypertension) benefit from free care. At the end of the experiment, persons receiving free care had better visual acuity, and some of them had lower blood pressure. From the latter improvement we infer that their risk of early death had been diminished. Although differences between income groups were insignificant, the improvements appeared to be greater among the poor.

To illustrate the magnitude of the gains, consider an average 50-year-old man, who in the late 1970s had approximately a 5 per cent chance of dying within five years.[28] A 50-year-old man at elevated risk had approximately double that chance of dying. If 1000 50-year-old men at elevated risk were enrolled in a free insurance plan, we could anticipate that 10.5 of them, who would otherwise have died, would be alive five years later

Table 7. Predicted Exit Values for Physiologic Measures and Health Habits in Elevated-Risk Groups, According to Measure and Plan.

Health Habits and Physiologic Measures	Definition of Elevated-Risk Group *	Total Cost-Sharing	Free Plan	Free Minus Cost-Sharing †
Smoking	≥1.79 (≥1 pack per day)	1.75	1.73	−0.02 (−0.06, 0.03)
Weight	20% over ideal weight (kg)	89.1	89.4	0.3 (−1.1, 1.7)
Cholesterol level	≥220 mg/dl	242	244	2 (−3, 7)
Diastolic blood pressure	>83 mm Hg or taking hypertension drugs at enrollment	89.3	87.9	−1.4 (−3.0, +0.1) ‡
Functional far vision	Line 3 (20/25) or worse for better eye	2.98	2.78	−0.2 (−0.3, −0.1) §
Risk of dying	Risk >1.42	1.42	1.90	−0.21 (−0.39, −0.04) ¶

*Elevated-risk groups are the least healthy 25 per cent of the people as defined with respect to the individual health measure denoted in each row. For functional far vision, all persons with uncorrected natural vision worse than 20/20 are included.

†Numbers in parentheses are 95 per cent confidence intervals.

‡$t = -1.79$; $P = 0.07$. §$t = -3.29$; $P = 0.001$. ¶$t = -2.41$; $P = 0.02$.

Table 8. Differences between Free and Cost-Sharing Plans in Predicted Exit Values of Blood Pressure and Vision and the Risk of Dying, According to Initial Health Status and Income.

Physiologic Measures	Elevated Risk *	
	Low Income	High Income
Diastolic blood pressure	−3.3 (−5.9, −0.7)	−0.4 (−2.6, 1.8)
Functional far vision	(−0.3 (−0.6, +0.02)	−0.1 (−0.4, 0.2)
Risk of dying	−0.30 (−0.60, −0.04)	−0.13 (−0.40, 0.10)

*For definitions of elevated risk for diastolic blood pressure and risk of dying, see Table 7. For functional far vision, elevated risk in this table refers only to the upper one quarter of the distribution of values for uncorrected natural vision. Predictions in these two columns were made with use of the mean value of the elevated-risk group. Numbers in parentheses are 95 per cent confidence intervals. All intervals that do not include 0 are significant at $P<0.05$.

$(1000 \times 0.05 \times (2.11 - 1.90) = 10.5)$. An average 39-year-old woman, on the other hand, had only a one per cent chance of dying within five years[28]; free care given to 1000 high-risk women would be expected to keep only two more women alive than would care provided under cost-sharing arrangements.

These mortality reductions, in and of themselves, are not sufficient to justify free care for all adults; investing in more targeted programs such as hypertension detection and screening would be a more cost-effective method of saving lives.[28] If there are other life-saving benefits that free care yielded — for example, a reduction in cancer deaths because of increased or more appropriate screening — such a conclusion could change.

Precisely how increased use of care led to improvement in some measures of health status and why it did not in others are not yet known. Future analysis of data collected during the experiment will examine the use of services and the quality of care provided to patients with hypertension and visual impairments, as well as to persons with a host of other conditions or problems not reported on here.

Our results must be used with caution to derive policies for special groups in the population. In our study, poor families were protected by an income-related ceiling on their out-of-pocket medical expenses. The aged and those too disabled to work were not included in the experiment, and in any event additional medical care for such persons may provide benefits that a young, relatively healthy population does not experience.

Future studies will evaluate the benefits of free care that have already been observed, as well as other possible benefits, relative to their costs. At this juncture, however, we conclude that although free care did not improve health status across the entire range of measures or income groups examined, it did confer demonstrable benefits for patients with selected conditions that physicians are trained to manage.

We are indebted to the following persons for their unique contributions in particular areas: Carolyn Andre, Rae Archibald, Marie Brown, Maureen Carney, Lorraine Clasquin, and Ken Krug (administration); Anita Stewart (measurement of physical functioning, smoking, and weight); Randi Rubenstein (measurement of vision impairment); Janet Hanley (programming); Darlene Blake, Carol Edwards, Joan Keesey, Bryant Mori, Susan Polich, Martin Seda, David Stewart, and Beatrice Yormark (data processing); and Barbara Eubank and Marilyn Martino (secretarial assistance); to the National Opinion Research Center and Mathematica, Inc., who collected the survey data; to the Health Testing Institute and American Health Profiles, who collected the physiologic data; to James Schuttinga and Larry Orr for support and guidance in their capacities as project officers from the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services; and to their superiors through the years whose support made this endeavor possible.

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MEDICAL PROGRESS

VARICELLA AND HERPES ZOSTER

Changing Concepts of the Natural History, Control, and Importance of a Not-So-Benign Virus

(Second of Two Parts)

THOMAS H. WELLER, M.D.

Patients at High Risk of Morbidity or Mortality from Varicella–Zoster Virus

Recognition of the potential severity of varicella in immunocompromised patients dates from our postmortem studies of two children who contracted chickenpox; one child had rheumatic fever and was receiving cortisone therapy, and the other was being treated for a neuroblastoma.[96,97] The latter case demonstrated that in such patients infections with varicella–zoster virus may be bizarre. When death occurred, in addition to the generalized lesions that had appeared in continued crops for 17 days, there was a zosteriform concentration of lesions over the right T-10 dermatome.

The risk of severe infection is high when the immunologic insults of hematopoietic or reticuloendothelial cancer are compounded by those of cytotoxic or immunosuppressive therapy. Severe varicella–zoster occurs frequently in children being treated for Hodgkin's disease, non-Hodgkin's lymphoma, or lymphocytic leukemia. In Hodgkin's disease the frequency has been reported to be 22 and 35 per cent.[98,99] In one series of patients who contracted varicella while receiving therapy, 32 per cent had visceral involvement, with a mortality rate of 7 per cent.[100] However, zoster in such patients is usually not fatal,[101] although death may follow visceral involvement, with pneumonia, hepatitis, or encephalitis predominant. Numerous studies suggest that an impaired cellular immune state is the major contributing factor. As in the immunocompetent patient, the risk of dissemination increases with age. Representative observations are that absolute leukopenia correlates with severe visceral involvement,[100] that patients with reticuloendothelial cancer frequently have a lowered response to the lymphocyte-transformation test,[102,103] and that the viral-inactivating capacity of the white cells is low.[104] Gershon and Steinberg reported that all 12 of their patients had demonstrable humoral antibody, even though 4 died.[104] In a prospective study, suppression of specific cell-mediated immunity preceded each episode of reactivation.[105] Although defective cellular immunity has been established as a major factor in disseminated infections, the role of depressed humoral responses remains controversial.[106] After the appearance of localized zoster in the high-risk patient, administration of zoster immune globulin does not reduce the frequency of dissemination[107] or affect the clinical course after dissemination.[108] However, as described by Zaia,[109] extensive experience has established the value of passive immunization for modification of the primary attack of varicella in the exposed high-risk patient.

Infections with varicella–zoster virus are a major problem in the subset of patients with leukemia or aplastic anemia who receive marrow transplants after high-dosage radiochemotherapy. In a group of 140 marrow recipients, including 89 who survived longer than six months, 92, or 65 per cent, had a clinically apparent process; zoster developed in 77 patients, with dissemination in 22, and in 15 the first manifestation was a generalized rash. Seven patients with an active infection died, and most of them had pneumo-

From the Department of Tropical Public Health, Harvard School of Public Health, 665 Huntington Ave., Boston, MA 02115, where reprint requests should be addressed to Dr. Weller.

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BUSINESS AND THE FAMILY

By Michael Fedo

MINNEAPOLIS

The American family in transition is a subject of concern to sociologists, psychologists and theologians. Of late, the importance of the family and its impact on worker productivity and effectiveness has also impressed the corporate world.

Arranging for competent child care, coping with alcoholism, drug abuse and rebellious teen-agers are only a few of the problems that affect workers' families — and, in turn, their jobs.

Many companies now recognize that a worker's family life cannot be viewed as separate from the workplace. "The unhealthy employee is not a productive employee," said Dr. Sue Wester, director of medical services at General Mills Inc. And the health of an employee is no longer confined to his own well-being. A child who has run away, for instance, can absorb an employee's concentration on the job.

The seeds of corporate efforts to assist workers through family and personal crises are rooted in the now widespread attempts by many companies to help workers and their families deal with the problem of alcoholism. It is cheaper for companies to help an alcoholic worker recover than it is to train someone new to take over that job. Now this theory has been extended into other areas of family life as well.

Not all company efforts at involvement in a worker's family life are quite as serious, however.

The Sperry Corporation here, in addition to its other counseling services, treats families to a yearly Mother's Day brunch complete with a special phone bank for free 5-minute long-distance phone calls to Mom.

Sperry was also one of the first companies to offer "Take a Taxi on Us," a program under which employees and their family members who have overindulged in drugs or alcohol are encouraged to take a cab home at company expense, rather than drive.

"Getting involved with employees' families has become a corporate social responsibility," said James Shannon, director of the General Mills Foundation, the philanthropic arm of the Minneapolis-based company.

'Flex-Time' Weaves Job and Family

NO one thinks it unusual when Sarah Shipley, a senior applications analyst at the Control Data Corporation, takes a work break to change her 9-month-old daughter, or when she fixes lunch for her 3-year-old daughter and reads her a story. That's because Mrs. Shipley works at her home in Dallas on what is known as a flex-time schedule. Back in April 1981, Control Data's Dallas office installed a computer terminal in Mrs. Shipley's home so she could continue her work as a programmer while she raised her family.

This isn't a common occurrence at Control Data, but it does indicate the company's willingness to be flexible to accommodate a valued employee. Other companies also allow employees leeway in arranging their work schedules to accommodate family needs — so they can be at home when children leave for school, for example, or home when the youngsters return.

Mrs. Shipley says she has always enjoyed her job, but was committed to raising her children. Now she can continue her career while staying home with her daughters. The company says that work such as programming can be done away from the office, but Mrs. Shipley said that there are certain disadvantages to the arrangement. "It's a lot of hard work," she said. "I try and work during normal working hours, but find I do a lot of work at night after the children are in bed. I'm committed to getting my hours in and giving the company its money's worth."

There are other drawbacks, too. She explained that while at home she has reached a plateau in her present position and won't get promoted. As her children start school, she expects to return to the office.

Thomas Hoffmann, a professor in the School of Management at the University of Minnesota, says that use of flex-time is on the rise in American corporations, especially among professionals. And he said he expects the trend to widen as the United States continues its transition from a production to a service economy.

The phenomenon can be traced in part, Mr. Hoffmann said, to society's changing attitudes toward the 8-to-5, 40-hour workweek. "For example, people with three or four weeks' vacation may not want to take it all at once, but rather spread it around — a couple days here and there, or a few afternoons off." He also said service industries are better able to accommodate the flexible schedules favored by many employees than are manufacturing facilities.

One early adaptation of flex-time, Mr. Hoffmann said, has been in the retail industry. "They use it to stay open longer," he said. "People want services, and flex-time enables a business to provide those services over a greater time period."

Elsewhere at Control Data, some jobs are shared, mainly by women whose children are in school or whose husbands travel. For example, a secretarial post in the office of employee communications at the company's Minneapolis headquarters has been shared for the past 18 months by Linda Maikke and Jeannette Armatas.

Mrs. Armatas, who works two days a week, says the time off enables her to travel with her husband, who is frequently on the road.

Mrs. Maikke, who works the other three days, says she likes the arrangement because it gives her more time to spend with her children and to do volunteer work. "It's really nice because you can take off those extra days and don't have a load of work to clean up when you return," she said. Another advantage, she said, is that each worker complements the other. "Some tasks she doesn't like, I enjoy, and vice versa." ■

Michael Fedo is a communications teacher and writer in Minneapolis.

When Violence at Home Affects Work

WHEN a woman reported for work with facial cuts and bruises for the third time, her supervisors grew concerned. Checking records at the Minnesota company's health maintenance organization, they learned that the woman's teen-age daughter had recently been raped and that her two preschool children had also received emergency room treatment twice within the past six months. The woman steadfastly refused to discuss what had happened to her, but her work was suffering and it was apparent to supervisors and coworkers that there were serious problems within her family, probably from an abusive husband.

This woman's case, while shocking, is not that unusual. But fortunately for her, the company did not turn its back. Corporations across the country are beginning to realize that family violence is an issue that won't go away, and one in which a corporate incursion into employees' personal lives, while controversial, can make a difference.

In the Twin Cities, a recently formed nonprofit company called Responses Inc. has begun working with a number of the area's largest companies to help bridge the gap between medical, business and governmental agencies in treating the problem of violence and sexual abuse within families.

"Abusers and their families exhaust a tremendous amount of health care and community resources," said Debra Anderson-Ten Bensel, executive vice president of Responses Inc. "It costs $108,000 per year to send a severely emotionally damaged child to a residential psychiatric center."

Violence and abuse within families may often be identified at the workplace, said Mrs. Anderson-Ten Bensel, pointing to excessive absences, excessive use of health benefits, anger on the job and botched work.

What Responses Inc. does, said Ed Scharlau, employee assistance manager at the 3-M Company, is to bring all involved parties together — the courts, attorneys, parents, employers and medical personnel. A family having problems with violence is told it can avoid the court process by admitting that there is a problem, then completing counseling arranged by Responses Inc. and the employer at the company's expense. If the family denies the existence of a problem, the court procedure takes over.

According to Mrs. Anderson-Ten Bensel, the traditional avenues for dealing with family violence are geared to the poor and minorities. "But this is not just a welfare and poverty issue," she said. Middle- and upper-income families have the problem, too. "For them it's as significant as chemical dependency. They're just better at hiding, and can hire attorneys to fight it." She said one local executive has spent $46,000 in legal fees to fight accusations that he sexually abused his 3-year-old and 5-year-old children.

But companies cooperating with Responses Inc. are less interested in punishing offenders than they are in helping families identify their problems, manage themselves and function normally and productively. While the process can be long and difficult in some cases — as it is with the woman and her family in the abuse case cited above — the recognition that there is a problem is a major first step. ■

Dealing With Dismissal

A MIDDLE-AGED executive is fired by a company where he's worked for 16 years. He's devastated, and so is his family. According to Compass Inc., a Minneapolis-based counseling service for displaced executives, the issue is not whether the firing was fair, but what subsequently happens to that person and his family.

Alan Sweetser, founder of Compass Inc., has been counseling displaced executives here since 1978, and has worked with nearly 200 former executives to help them through the crisis periods that follow termination. Such "out-placement counseling," paid for by the terminating company, is becoming increasingly common across the country.

But companies in the Twin Cities using Compass Inc. are extending this counseling to the executives' spouses as well.

Mr. Sweetser said that while he's beginning to see women executives, the majority of his clients are men. He describes his typical client as "angry and hurt. But we've found out there's more anger and resentment on the part of his wife. She knows how much energy he's given to his job and how many birthdays and anniversaries he's missed because of work. And she's very bitter at the company for sacking him."

"These people aren't sacked because they're incompetent," Mr. Sweetser added. "Usual causes for firing are a new boss, a change in company direction, or staff reductions." Once a wife understands this, he said, she is able to become more supportive of her husband in his quest for another position.

Marilynne Anderson, director of the spouses' program at Compass Inc., said that wives of dismissed executives have the same anxieties as their husbands. "Husbands get some relief from counseling, but until recently, there was no relief for the woman. She didn't feel totally adequate to help her husband, and in some cases may have thought that by having him perform tasks around the house, he'd get his mind off his problems."

Counseling wives, Mrs. Anderson said, helps them gain a greater understanding of what their husbands are going through. And it also gives them opportunities to vent their own feelings and frustrations. "They are usually reassured to learn that 97 percent of our clients find new positions," she said.

Compass Inc., however, is not a placement service. It provides counseling and support until a client finds new work. Such counseling includes help in writing a résumé, techniques for using business contacts to locate a new position, and helping the client realize his strengths so that he feels like a capable person with qualities that another company would value. ■

Betty Stowers - MHA #13 - 2-29-84

TESTIMONY BEFORE PUBLIC HEALTH & WELFARE
February 29, 1984
on S.B. 781

Chairman Myers and members of the Committee:

The Mental Health Association has long advocated for the inclusion in health benefit policies of mandatory minimum treatment for mental and emotional illness. Mental illness remains America's #1 health problem. Mental and emotional disabilities interfere with many Americans functioning in the workplace. However, a person with mental illness, unlike most others suffering from a physical illness and disability, will be denied access to most benefit programs. Such discriminatory policies and practices result in higher health care costs to the patient and further stigmatization of mentally ill persons.

To save your time, I shall stress just one important result of inclusion of coverage of mental health treatment as stipulated in S.B. 781.

The Mental Health Association has fought long and hard to reduce the stigma faced by those who suffer from mental illness. Failure to seek proper treatment is frequently caused by many forms of stigmatization. Many persons, sometimes society itself, refuse to acknowledge the extent of incidence of mental illness and there has been too little advocacy on the part of patients and their families who fear exposure to stigma as a result of such advocacy.

The mere removal of the discrimination against treatment of mental illness, currently not covered in most insurance policies and the

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inclusion of treatment for mental illness as mandated in S.B. 781 would do much to reverse the stigma. Recognition of their right to receive insurance coverage for such treatment, would "legitimatize" mental illness. This would encourage early intervention and proper care, which in turn could shorten the duration and expense of treatment.

I strongly urge that you recognize the right of the mentally ill to fair and adequate access to treatment and legislate by the adoption of S.B. 781, appropriate mental health coverage.

Thank you for the opportunity to appear before you and your courteous attention.

To: Senate Committee on Public Health and Welfare

From: James A. McHenry, Jr., Ph. D., Commisioner

Date: February 29, 1984

RE: SB 781

Senate Bill 781 would benefit the citizens of Kansas by helping remove the stigma associated with alcoholism and drug abuse and by improving accessibility to services for the alcoholic, the drug abuser and their families.

In Kansas, there are people who are having difficulty getting admitted to alcohol and drug abuse treatment if they do not have insurance coverage but have income/assets over the cutoff level for MediKan. These may be the persons who are now overloading the State Hospital Alcohol Treatment Unit's because the hospital programs can only accept so many who can not pay and the Intermediate programs are primarily designed for those people who are eligible for General Assistance.

This bill would benefit many groups of persons needing alcohol and drug abuse services, including youth and elderly. The earlier a person is confronted with the fact that he/she has an alcohol and/or drug problem, the easier it is to treat them. We know that if the illness is arrested at an early age, there will be less costs incurred in treating the symptoms of the illness in medical care and other facilities. The mandates of Senate Bill 781 would allow parents of troubled youth to refer their children to appropriate treatment without having to bear the high cost of these services out of their pocket at one time.

Studies have shown that at least 10% and maybe as high as 20% of the elderly have a serious problem with alcohol and/or drugs. Among those elderly that that have additional medical, family or emotional problems, the rate may be higher than 25%. If many of the elderly had coverage through their insurance, they would be able to receive treatment for their problem, and not continue to incur high medical bills to treat only the symptoms of their problem.

The Illinois Bell Telephone employee alcoholism program, one project among many, has shown the the costs associated with mandated alcohol and drug abuse treatment coverage are minimal. There has been extensive research showing the cost effectiveness of this type of mandated coverage. Individuals who have received treatment for their alcohol/drug problem show a decreased use in all health care related costs. Significant cost savings also accrue to employers due to decreased sick time, decreased accidents on and off the job and decreases in workers compensation claims. Overall, those individuals who received treatment for their alcohol/drug problem have shown that the cost for having the mandated coverage is far less than the long term savings it produces.

I urge you to join other groups, including the Presidential Commission on Drunk Driving, in supporting this bill.

I would like to thank the chairman and the members of this committee for permitting me to share these views. I will be happy to answer any of your questions.

1306B

KANSAS ALCOHOLISM AND DRUG ABUSE COUNSELOR'S ASSOCIATION

TO: PUBLIC HEALTH and WELFARE COMMITTEE

FROM: Glenn Leonardi, Representing the Kansas Alcoholism and Drug Abuse Counselor's Association

SUBJECT: Senate Bill No. 781

DATE: February 29, 1984

I appear before you today on hebalf of the Kansas Alcoholism and Drug Abuse Counselor's Association (KADACA) to voice our association's support of Senate Bill No. 781.

KADACA is a professional organization of over two hundred and fifty certified alcoholism and drug abuse counselors representing the entire state of Kansas. The association's purpose is to develop and maintain professional standards and to insure delivery of quality services by the members of this profession.

In the last decade the stigma associated with alcohol and other drug abuse problems has been greatly reduced. As a result, fewer clients and their families are prolonging the suffering related to such problems. Our society is gradually understanding and dealing with what has become our nation's third major health problem. Your consideration of Sentae Bill No. 781 clearly reflects our need to establish social policy that can effectively address the needs of Kansas.

Our association is aware and supportive of the techinical points addressed by the Kansas Association of Alcohol and Drug Program Directors and we respectfully request your support of this legislation.

I nsas
Citizens
Advisory
Committee on Alcohol and other Drug Abuse

P.O. BOX 4052 TOPEKA, KANSAS 66604

February 28, 1984

Sen. Jan Meyers
Public Health and Welfare Committee
Kansas State Capitol
Topeka, Kansas

Re: SB 781

Dear Committee Members,

The Citizens Advisory Committee on Alcohol and other Drug Abuse strongly supports SB 781. Although Kansans are currently offered optional alcohol and drug abuse coverage, only a small percentage are insured. People simply don't think that they will ever have an alcohol or drug abuse problem. As a result, most Kansans are treated in tax supported programs. We feel that given the seriousness and extent of these problems in Kansas this coverage should be required.

Respectfully submitted,

Bruce H. Beale
Chairman

H14- 2-29-84

BANKERS LIFE NEBRASKA

GROUP CLAIMS DIVISION
Wichita Claim Office
955 Parklane
Wichita, Kansas 67218
Telephone (316) 686-1337

February 29, 1984

For Presentation to the Kansas Senate Public Health and Welfare Committee

Madam Chairperson, Committee Members and Interested Parties:

My name is William E. Horn. I am the Group Claim Manager-Wichita for Bankers Life Nebraska. I have been in the insurance business 32 years and the last 17 years with the present company.

This opportunity to express a few words against S.B. 781 is sincerely appreciated. We strongly feel an insurance policy should be written for the benefit of the policyholders and not for the benefit of the provider of a service covered by that policy. We feel the policyholder and not the provider should have the right to determine the level of care it is willing to pay for. Accordingly, "unless refused in writing," are words of utmost importance and should remain in K.S.A. 40-2, 105.

Historically to mandate coverages results in higher fees or increased utilization or both over that seen in voluntary coverages provided. This results in higher premiums passed on to the policyholders. Many of those policyholders who refuse in writing the provisions of K.S.A. 40-2, 105 do so with the intent of providing far more coverage and more expensive coverage but yet cost effective coverage for the employees of a group.

Many policyholders today are very sophisticated in the purchase of health benefits and determining the needs of employees through the purchase of services of professionals in the health provider field. Treatment programs for nervous disorders and substance addiction programs are studied

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and coverage then sought in the most cost effective way. We have more policy restrictions and limits today on mental and nervous disorders than we had in 1967 and more of the same on substance abuse programs than when we first provided this coverage in 1969. At that time we could provide coverage on a voluntary basis. When mandates arrived in 1974 costs during the next year increased dramatically and controls and restrictions had to be set. As a result, we now provide for less treatment at a greater cost.

Cost containment is much in the news today because of extremely high increases in medical costs for several years. Cost containment must be for the efficient use of those dollars available to provide for treatment. Mandating coverage for providers is not a cost effective mechanism. For the past five years I've worked with the Sedgwick County Round Table for Cost Containment. This group of leaders in labor, management, medical, hospital and insurance fields has sat periodically to wrestle the problems of health costs. These problems are multiple and house bill S.B. 751 can only add to the problems.

Providers of health insurance coverages are being challenged today by alternate delivery programs. Health Maintenance Organizations, Preferred Provider Organizations, Individual Practice Associations and Self Insurance Arrangements grow annually. Legislative restrictions on insurance coverages can drive more and more individuals to these other delivery systems. Those providers who would ask for this legislation today could find themselves

outside of any coverage if the trend continues. It will be far better for all if the insurance provisions are negotiated rather than legislated.

Thank you very much for listening and I trust these comments will be weighed in you final decision.

Respectfully Submitted

William E. Horn, FLMI

Group Claim Manager-Wichita

Beech Aircraft Corporation
Wichita, Kansas 67201
U.S.A.

STATEMENT BEFORE THE KANSAS SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

FEBRUARY 29, 1984

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS MARSHA HUTCHISON FROM BEECH AIRCRAFT CORPORATION. WE HAVE AIRPLANE MANUFACTURING PLANTS IN WICHITA, LIBERAL, SALINA, NEWTON AND ANDOVER. WE APPRECIATE THE OPPORTUNITY TODAY TO EXPRESS OUR RESERVATIONS CONCERNING SENATE BILL 781. WE ARE OPPOSED TO THIS PROPOSED LEGISLATION.

AT THE OUTSET WE'D LIKE TO INDICATE OUR APPRECIATION FOR THE SERVICES RENDERED BY HEALTH CARE PROFESSIONALS OF ALL LEVELS THROUGHOUT KANSAS. WE ARE PLEASED WITH THE VALUABLE ASSISTANCE THEY PROVIDE OUR EMPLOYEES.

BEECH IS A LEADER IN PROVIDING A LIBERAL PLAN OF BENEFITS FOR THE TREATMENT OF MENTAL ILLNESS, ALCOHOLISM AND DRUG ABUSE. OUR INSURANCE PLAN COVERS BOTH INPATIENT AND OUTPATIENT TREATMENTS. BEECH ASSISTS EMPLOYEES IN IDENTIFYING MENTAL HEALTH, ALCOHOLISM AND DRUG ABUSE PROBLEMS

Attch. 14

THROUGH ITS PARTICIPATION WITH EMPAC (EMPLOYEE ASSISTANCE CONSULTANTS), AN EMPLOYEE PROBLEM IDENTIFICATION AND REFERRAL AGENCY. WE WERE AMONG THE FOUNDERS OF EMPAC, WHICH IS ENTIRELY FUNDED FROM CORPORATE SOURCES.

OUR BENEFIT PLAN WAS DESIGNED TO REQUIRE SERVICES OF THE MOST QUALIFIED PROFESSIONALS AVAILABLE WHEN TREATING SERIOUS MENTAL DISORDERS, ALCOHOLISM AND DRUG ABUSE. AS A PRACTICAL MATTER OUR INSURANCE PACKAGE REIMBURSES FOR MENTAL HEALTH CARE RENDERED BY A PHYSICIAN OR CERTIFIED PSYCHOLOGIST, AND FOR ALCOHOLISM AND DRUG ABUSE CARE RENDERED BY PHYSICIANS, CERTIFIED PSYCHOLOGISTS AND OTHER HIGHLY QUALIFIED PROVIDERS APPROVED BY BEECH AIRCRAFT CORPORATION. K.S.A. 40-2, 105 PERMITS AN EMPLOYER (THE PURCHASER OF INSURANCE) TO REJECT, IN WRITING, COVERAGE FOR TREATMENT BY OTHER PROVIDERS. WE HAVE REJECTED IN WRITING THE COVERAGE OF OTHER LOWER LEVEL PROVIDERS. IN OUR JUDGEMENT SB 781, IF ENACTED, WOULD INCREASE MEDICAL COSTS BY REQUIRING EXPANSION OF THE NUMBER OF COVERED MENTAL HEALTH, ALCOHOLISM AND DRUG ABUSE CARE PROVIDERS TO INCLUDE OTHER LOWER LEVEL PROVIDERS SUCH AS BACHELOR LEVEL PSYCHOLOGISTS OR COUNSELORS.

AT THE CENTER OF THIS QUESTION IS WHETHER THE LEGISLATURE WISHES TO MANDATE THE KIND OF INSURANCE PACKAGE THE PURCHASER IS REQUIRED TO BUY. WE HAVE NO PROBLEM WITH DIRECTIONS GIVEN TO INSURANCE COMPANIES CONCERNING THE KIND OF PACKAGE OFFERED. HOWEVER, AS THE CONSUMER WE SHOULD BE ALLOWED A CHOICE WHETHER WE WANT SUCH COVERAGE OR SOMETHING TAILORED TO OUR SPECIFIC NEEDS.

THROUGH THE COLLECTIVE BARGAINING PROCESS A SPECIFIC PLAN WAS NEGOTIATED. INACTMENT OF THIS PROPOSED LEGISLATION WOULD ALTER THIS NEGOTIATED PACKAGE OF FRINGE BENEFITS, INCREASING COSTS AT A TIME WHEN WE ARE ESPECIALLY CONCERNED ABOUT ESCALATING HEALTH CARE EXPENDITURES.

IN OUR JUDGEMENT THE PROPOSED BILL IS UNWARRANTED. IT FORCES OUR COMPANY TO ACCEPT COVERAGE WE DO NOT WANT AND DO NOT WANT TO PAY FOR.

THANK YOU.

H 15- 2-29-84

STATE OF KANSAS

JOAN WAGNON
REPRESENTATIVE, FIFTY-FIFTH DISTRICT
1606 BOSWELL
TOPEKA, KANSAS 66604

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: JUDICIARY
LEGISLATIVE, JUDICIAL AND CONGRESSIONAL APPORTIONMENT
PENSIONS, INVESTMENTS AND BENEFITS
PUBLIC HEALTH AND WELFARE

Summary of Domestic Violence Program Funding

Data collected on 14 of 19 programs by telephone this week (No information on Dodge City, Emporia or Kansas City, Ks.; There are new programs in Hays, Colby, each receiving $3000 from Crime Victims Reparation Board.)

Total Expenditures, all programs $657,207

Total Income		
Gov't Grants	$295,831	48%
United Way	158.471	25%
Foundations/Churches	15,300	
Other income	50,765	
*Private Donations	98,133	
	618,500	

*This figure is unrealistic to achieve and frequently represents the unfunded portion of the budget.

Why additional funding is needed:

1. Current level of funding is inadequate to cover operating expenses — (38,707) Great Bend, Garden City, Johnson Co., Lawrence

2. Private fundraising estimates are unrealistic given United Way Restrictions on fund raising and lack of staff — (50,000) Manhattan, Pittsburg, Salina

3. Government grant funding is declining from federal sources — (47,000) Wichita; (18,760) Family & Children Trust Funds; (154,467) Leavenworth, Dodge City, Emporia, Atchison, etc

4. Services are not fully developed in many communities and need additional funds.

Att. 15

Location of Program	Atchison	Concordia	Garden City	Hutchinson	Johnson Co	Leavenworth	McPherson
T of Service	Safe Homes	1 Safe Home	Safe Homes Hotline	Use local Motels	Safe Homes	Hotline, Tranport to another shelter	Safe Homes Sexual Assualt
Source of Income & Totals for Current Fiscal Year	No funds	$600	$9,549	$1150	$48,000	$2400	$4900*
1. Government Grants Family & Children Trust Fund							
Title XX Block Grant Social Services							
Community Development Block Grants						$25,000*	
Alcohol Tax Monies (SB 467 or SB 888)					$20,000		
General Revenue Sharing (local)					$ 2,000		
Crime Victims Reparation							
2. United Way			$8954	$1150	$13,500	$2400	$1750
3. Foundation Grants or Churches		$600			$12,000		
4. Other Income supplemental fund raising projects			$595		$500		
5. To Be raised by private donars							$1450 Cash $1700 in-kind service
Total Projected Expenditures (currect fiscal year)	0	$600	$10,571	unknown	$54,000	$2400	$4900 for Domestic Violence
Number Clients Served (adults only, unduplicated)	unknown	4-6/mo.	unknown	12/14/mo.	565	unknown	15-25
S fing Pattern	volunteer	volunteers		volunteer	2FT 11PT volunteers	loaned from another program	1PT

Location of Program	Lawrence	Topeka	Manhattan	Pittsburg	Wichita	Great Bend	Salina
T_ of Service	Shelter	Shelter	Shelter	Shelter	Shelter	Shelter & Rape Program	Safe Homes
Source of Income & Totals for Current Fiscal Year	$57,236	$83,313	$121,094	$43,000	$170,848	$ 18,700	$68,300
1. Government Grants							
Family & Children Trust Fund	$7590		$7400*				$3770
Title XX Block Grant Social Service			$12,000 ?	$10,000		$3000	
Community Development Block Grants					$147,843*		
Alcohol Tax Monies (SB 467 or SB 888)	$8840			$3,000		$8200	$5000
General Revenue Sharing (local)	$11,150 City $5400 Gen.Fund $1923 County	$20,850 City 14,865 County					
Crime Victims Reparation				$10,000		$4000	$4000
2. United Way	$14,333	$39,536	$18,809 Riley 9,300 Geary 1,000 Wamego		$5,000	$3000 $ 500	$39,239
3. Foundation Grants or churches	$2700						
4. Other Income supplemental fund raising projects	$3600*	$2300	$40,000 Army				$3770 Corporate gift
5. To be raised by private donors	$1700	$5762	$37,000	$20,000	$18,000	Balance of Budget	$12,521
Total Projected Expenditures (current fiscal year)	$58,714	$83,313	$121,094	$43,000	$171,000	$39,315	$68,300
Number Clients Served (adults only, unduplicated)	152	500	591	400 women & children	550	216	269
_ffing Pattern	1½ Cut from 3	3FT 1PT	4FT	1FT 1PT	8FT 1PT 1 weekend	2FT 2PT	3FT ½Counselor

Location of Program	Lawrence	Topeka	Manhattan	Pittsburg	Wichita	Great Bend	Salina
Comments	*KU Student Senate Budget Short $1478	Revenue sharing may decrease in future	*Final year of funding		*Likely to be reduced to $100,000 next year	Only Shelter between Wichita & Colorado border; serves other programs	

Comments	Atchison	Concordia	Garden City	Hutchinson	Johnson Co.	Leavenworth	McPherson
			$1022 short to fund current budget		Deficient of $6000 in income	*Grant pending to expand services	*includes donated services such as rent, duplication