Approved March 14, 1984
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers, Chairperson, at 10 a.m./~~p.m.~~ on March 2, 1984 in room 526-S of the Capitol.

All members were present except:

Senator Roitz, excused, and Senator Francisco

Committee staff present:

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

Conferees appearing before the committee:

Senator Jack Steineger
Ruth Lyon, Chairman, AARP, Independence
Morton F. Ewing, Vice Chairman, AARP, Hutchinson
Don Wilson, President, Kansas Hospital Association
Lynelle King, Kansas State Nurses Association
Marlon Dauner, Blue Cross-Blue Shield
Richard Charlton, ADAPT

Others present: see attached list

SB 541 - Hospital Cost Containment Act

Senator Jack Steineger testified in support of SB 541 and submitted testimony stating that we have one of the highest rates for both hospital admissions and length of stay for any group in the nation, and this bill addresses the problem by establishing a Kansas Hospital Commission and providing for a uniform system of financial reporting by hospitals. Senator Steineger stated that we are reaching a crisis point in health care and the people of Kansas expect us to take action to avert a disaster in health care. (Attachment #1). Senator Steineger also distributed information concerning Health Care Expenditures in Kansas. (Attachment #2).

Ruth Lyon, Chairman, American Association of Retired People, testified in support of SB 541 and distributed testimony stating that the hospital costs continue to rise at 15% per year. State regulation would not add to hospital costs, and there is no well-substantiated evidence that the quality of care in the cost containment states has suffered. In the states with mandatory cost controls, there is no evidence that physicians have changed their affiliations or left the state because of state regulation. Patients are not to blame for rising hospital costs. More cost sharing - such as increasing copayments and deductibles - would not result in greater savings than mandatory cost containment programs, and hospital closings are unrelated to mandatory cost containment programs. Hospital cost containment programs do not force hospitals into ruinous financial situations. (Attachment #3).

Morton F. Ewing, Vice Chairman, AARP, Hutchinson, testified in support of SB 541 and distributed testimony stating that AARP supports both regulatory and competitive market approach to health reform, but for the short term they support a regulatory approach that includes cost controls at the federal and state levels for all payers and a cap on capital expenditures. AARP feels there should be a commission with regulatory power; a uniform system of financial reporting; and an adivsory committee to give the commission advice on particular problems. (Attachment #4).

Don Wilson, President, KHA, testified in opposition to SB 541 and distributed testimony to the committee stating reasons for their opposition. Mr. Wilson said that state rate commissions are not in step with current third-party payer initiatives, and KHA urges the committee to allow the

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

major payers to continue to develop their systems of prospective payment. This will set what rates will be paid for hospital care, and still not impose another layer of bureaucracy on the industry. (Attachment #5).

Lynelle King, KSNA, testified in opposition to SB 541, and distributed testimony stating their concerns about the bill. They ask there not be furhter cost containment legislation until there has been time to observe effects of prospective payment systems (DRGs); similar commissions in other states have had a negative impact on the quality of nursing care; and the process a hospital would have to go through to gain a rate increase would be expensive. (Attachment #6).

Senator Johnston distributed an article to the committee entitled "Everyone's Entitled to Blame for Soaring Health Costs" by Gregory E. Pence, University of Alabama in Birmingham. (Attachment #7).

Marlon Dauner, BC-BS, testified in opposition to SB 541, saying that six hospitals have already taken initiatives to lower their costs and he believes the costs will not rise next year as they have this year.

Senator Meyers asked when he would have some comparative statistics on the costs and Mr. Dauner replied they should have them in July or August.

Richard Charlton, ADAPT, testified in support of SB 541 and stated that he supported AARP's position. He said he represented the disabled community and they have more needs because of their medical impairments. Mr. Charlton felt they were being priced out of quality health care market.

Additional testimony supporting SB 806 was distributed to the committee from: The Kansas Dental Hygienists; Jamie Menes, RDH; Mary Jo Nigg, RDH. (Attachments #8, 9, 10).

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-2-84

(PLEASE PRINT)

NAME AND ADDRESS	ORGANIZATION
Lynelle King	KSNA
Ruth M. Lyon	AARP State Legis Com.
Martha F. Ewing	AARP State Legis. Com.
Bill Overbey	KHA
Gary Reitz	KDOA
Marla R. Dauner	BCBS
Donald O. Wilson	KHA
Frank L. Gentry	Ks Hospital Assoc
Wayne Johnston	BC-BS
Jim McBride	United Way of Topeka
Terry Humphrey	Planned Parenthood of KS
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Rosemary O'Leary	KDHE
Julie Brown	Right to Life of Ks., Inc.
[illegible]	AG
Barb Reinert	Ks WP Caucus
Darlene Greer Stearns	Consultation of Churches
Marilyn Bradt	KINH
Diane Bottorff	KSNA
Ric Rehorn	Sen Steineger
Jack Roberts	BC-BS
Elizabeth E. Taylor	Ks Dental Hygienists Assn
January H. Scott	KCPCA
Kent Jackson	KS F&Game

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE____________________

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
RICHARD D. CHARLTON, SR. Rt 1, Box 348, WAMEGO, KS 66547	A-D-A-P-T, Inc
John Peterson	Ks Assn of Prof Psychologists

#1- 3-2-84

REMARKS BY SENATOR JACK STEINEGER
S.B. 541 - PUBLIC HEALTH AND WELFARE COMMITTEE
FRIDAY, MARCH 2, 1984

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, I APPRECIATE THIS OPPORTUNITY TO PRESENT ANOTHER PIECE OF THE 1984 DEMOCRATIC CONSUMER FAIRNESS PACKAGE, SENATE BILL 541.

I'M SURE THAT MOST OF YOU ARE ALREADY FAMILIAR WITH SENATE BILL 541. THIS BILL WOULD IMPLEMENT THE KANSAS HOSPITAL COST CONTAINMENT ACT AND ESTABLISH THE KANSAS HOSPITAL COMMISSION IN ORDER TO CONTROL OUT-OF-CONTROL HEALTH CARE COSTS.

AS WE ALL KNOW, IN THE PAST TWO DECADES, BOTH THE PRIVATE AND PUBLIC SECTORS HAVE SEARCHED FOR WAYS TO CONTROL OUR CONSTANTLY ESCALATING HEALTH CARE COSTS. ON THE NATIONAL LEVEL, THESE COSTS CONTINUE TO CONSUME MORE AND MORE OF THE GROSS NATIONAL PRODUCT---AND NO END APPEARS IN SIGHT.

IN 1981, THE LATEST YEAR FOR WHICH WE HAVE COMPLETE DATA, HEALTH CARE COSTS AMOUNT TO 9.8% OF THE GROSS NATIONAL PRODUCT, AN INCREASE OF MORE THAN 15% FROM THE PREVIOUS YEAR. THE INCREASE IN 1981, ALONG WITH THE 15.8% INCREASE IN 1980, WERE THE HIGHEST ANNUAL INCREASES IN 15 YEARS. MUCH THE SAME KIND OF INFLATION IS TRUE FOR KANSAS.

Atch. 1

ALTHOUGH THE HEALTH CARE PORTION OF OUR STATE'S ECONOMY HAS NOT GROWN AS FAST AS THE HEALTH CARE COMPONENT OF THE GROSS NATIONAL PRODUCT, OUR PER CAPITA HEALTH CARE EXPENDITURES HAVE GREATLY OUTSTRIPPED THE NATIONAL RATE OF INCREASE. LET'S LOOK AT THE FIGURES.

IN 1981, KANSANS SPENT $2.6 BILLION FOR ALL HEALTH SERVICES AND SUPPLIES---A 14% INCREASE FROM 1980.

IN 1981, KANSANS SPENT $1,014 EACH FOR PERSONAL HEALTH CARE SERVICES COMPARED TO $1,090 NATIONALLY.

IN 1981, KANSANS SPENT $491 EACH FOR HOSPITAL CARE COMPARED WITH $504 NATIONALLY---JUST $13 BELOW THE NATIONAL AVERAGE. COMPARE THIS TO 1978 WHEN WE FELL $20 BELOW THE NATIONAL AVERAGE, AND YOU BEGIN TO GET A PICTURE OF THE GROWTH IN HOSPITAL COSTS. IN FACT, DURING THE PAST 18 YEARS, HOSPITAL COSTS IN KANSAS INCREASED MORE THAN 13% A YEAR.

THESE INCREASED HOSPITAL COSTS SHOULDN'T SURPRISE ANYONE, BECAUSE IT APPEARS KANSANS---AS A GROUP---HAVE ONE OF THE HIGHEST RATES FOR BOTH HOSPITAL ADMISSIONS AND LENGTH OF STAY FOR ANY GROUP IN THE NATION.

S.B. 541 ADDRESSES THE PROBLEM BY ESTABLISHING A KANSAS HOSPITAL COMMISSION AND PROVIDING FOR A UNIFORM SYSTEM OF FINANCIAL REPORTING BY HOSPITALS. THE COMMISSION WOULD REVIEW HOSPITAL RATES PROSPECTIVELY AND HAVE THE AUTHORITY TO APPROVE OR DISAPPROVE THE RATES.

THE COMMISSION ENVISIONED BY S.B. 541 WOULD DIRECTLY ADDRESS THE PROBLEM OF SKYROCKETING HEALTH CARE COSTS BY IMPLEMENTING DIRECT CONTROL OF THOSE RATES. AT THIS POINT, MORE THAN HALF THE STATES HAVE IMPLEMENTED HEALTH CARE COMMISSIONS OF ONE FORM OR ANOTHER. MOST HAVE PROSPECTIVE RATE REVIEW POWERS, BUT ONLY SEVEN CAN REQUIRE COMPLIANCE. THESE COMMISSIONS HAVE MET WITH VARYING DEGREES OF SUCCESS, BUT OVERALL, THEIR IMPACT ON HOLDING DOWN HOSPITAL COSTS HAS BEEN GOOD.

PRESIDENT REAGAN HAS POINTED OUT THAT HEALTH CARE COSTS ARE A NATIONAL PROBLEM WHICH SHOULD BE ADDRESSED AT BOTH THE STATE AND NATIONAL LEVEL WITHOUT DELAY. THIS LEGISLATURE HAS GRAPPLED WITH THE PROBLEM IN ONE FORM OR ANOTHER FOR A NUMBER OF YEARS.

FRANKLY, I DON'T THINK WE'VE MADE MUCH PROGRESS IN ADDRESSING PROBLEMS HEALTH CARE COSTS PRESENT TO KANSANS. AND I THINK MANY KANSANS, PARTICULARLY OUR OLDER CITIZENS WHO ARE OFTEN ON FIXED INCOMES, ARE LOSING PATIENCE WITH US. AS YOU CONSIDER SENATE BILL 541, THERE ARE TWO THINGS YOU SHOULD BEAR IN MIND.

FIRST, THERE'S ABSOLUTELY NO REASON FOR FURTHER DELAY. EVERY YEAR WE DELAY TAKING ACTION TO CONTROL HEALTH CARE COSTS IN KANSAS, THE PROBLEM ONLY GROWS WORSE, NOT BETTER.

SECOND, IT'S OBVIOUS TO EVERYONE THAT WE DO HAVE A PROBLEM. THE POINT IS NEARING WHEN HEALTH CARE OR HEALTH INSURANCE WILL BE PRICED OUT OF THE REACH OF MANY KANSANS.

FINALLY, I WANT TO CALL THE COMMITTEE'S ATTENTION TO WHAT ONE HEALTH CARE EXPERT HAS CALLED THE "MOST IMPORTANT HEALTH CARE DEVELOPMENT OF THE DAY"---THE MOVEMENT AWAY FROM NON-PROFIT OR PUBLIC CONTROL OF HOSPITALS TOWARD MULTI-HOSPITAL, FOR-PROFIT CONTROL.

THIS TREND IS NOTHING NEW, BUT IT HAS GAINED IMPORTANT SUPPORT UNDER THE REAGAN ADMINISTRATION. REAGAN'S BUDGET DIRECTOR, DAVID STOCKMAN, HAS SUGGESTED A SYSTEM UNDER WHICH--AND I QUOTE--"MOST HOSPITALS WILL BECOME PART OF FOR-PROFIT MARKETING OPERATION OR THEY WILL BECOME FOR-PROFIT ON THEIR OWN."

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, I SUGGEST TO YOU THAT THIS TREND DOESN'T BODE WELL FOR EITHER THE PUBLIC OR HEALTH CARE COSTS.

FOR ONE THING, STUDIES SHOW THAT THERE IS NO EVIDENCE TO SUGGEST THAT FOR-PROFIT HOPSITALS ACHIEVE ANY SAVINGS OVER NONPROFIT HOSPITALS.

IN FACT, FOR-PROFIT HOSPITAL CHARGES AVERAGE 17 PERCENT MORE PER ADMISSION THAN COMMUNITY HOSPITALS. WHILE FOR-PROFIT HOSPITALS MAY BE EFFICIENT IN MAXIMIZING REIMBURSEMENT RATES, THEIR EFFICIENCY DOES NOT BENEFIT PATIENTS, OR THE PUBLIC IN GENERAL, THROUGH LOWER RATES.

ANOTHER FACET OF THE TREND TOWARD FOR-PROFIT HOSPITALS IS THE PROPENSITY FOR PROFIT-MAKING OPERATIONS TO DELIBERATELY LOCATE FACILITIES IN STATES WITH NO COST CONTAINMENT REGULATION. WHILE KANSAS HASN'T BEEN OVER-RUN BY THESE KINDS OF OPERATIONS, WE HAVE SEEN THE NUMBER OF KANSAS PROFIT-MAKING HOSPITALS GROW FROM TWO IN 1974 TO SIX TODAY---A THREEFOLD INCREASE IN THE PAST 10 YEARS.

AS I SAID, I DON'T BELIEVE THE TREND TOWARD PROFIT-MAKING HOSPITALS BODES WELL FOR EITHER CONSUMERS OR HEALTH CARE COSTS. PROFIT-MAKING HOSPITALS, IN THE FINAL ANALYSIS, AREN'T INTERESTED IN TREATING PEOPLE WHO CANNOT AFFORD TO PAY. THIS FACT, COUPLED WITH CUTBACKS IN PUBLIC FUNDING OF MEDICAL PROGRAMS, IS MOVING US TOWARD A TWO-CLASS SYSTEM OF HEALTH CARE, HARDLY AN IMPROVEMENT FROM A CONSUMER'S POINT OF VIEW.

SECONDLY, THE DRIVE TO MAXIMIZE PROFITS WILL FURTHER FUEL THE FIRES PUSHING HEALTH CARE COSTS INTO THE STRATOSPHERE. AT A TIME WHEN BOTH THE PUBLIC AND PRIVATE SECTORS ARE SEARCHING FOR WAYS TO SLOW OR CONTAIN THE GROWTH IN HEALTH CARE COSTS, WE FIND OURSELVES BESET BY YET ANOTHER FORCE WHICH WILL PUSH COSTS EVEN HIGHER.

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, I THINK IT'S FAIR TO STATE---WITHOUT RESERVATION---THAT WE ARE REACHING A CRISIS POINT IN HEALTH CARE. WE ARE REACHING THE LIMIT OF PEOPLE'S ABILITY TO PAY FOR EITHER HEALTH CARE OR HEALTH CARE INSURANCE. WE ARE REACHING THE LIMIT OF SOCIETY'S ABILITY TO ABSORB FURTHER RUNAWAY GROWTH IN HEALTH CARE COSTS.

IN CLOSING, I THINK WE SHOULD AKNOWLEDGE THAT WE DO FACE A CRISIS---AND THAT THE PEOPLE OF KANSAS EXPECT US TO TAKE ACTION TO AVERT A DISASTER IN HEALTH CARE. HEALTH CARE COSTS ARE THE NUMBER ONE PRIORITY OF AGING GROUPS THROUGHOUT THE STATE. HEALTH CARE COSTS HAVE BECOME A HIGH PRIORITY FOR PHYSICIANS---AS EVIDENCED BY THE LETTER SENT LAST WEEK TO 390,000 DOCTORS BY THE AMERICAN MEDICAL ASSOCIATION CALLING FOR AN "IMMEDIATE" FREEZE ON DOCTORS' FEES.

IF THIS LEGISLATURE INTENDS TO CONTINUE TO SIDETRACK EFFORTS TO CONTAIN EXPLODING HEALTH CARE COSTS BECAUSE OF PHILOSOPHICAL OBJECTIONS TO "REGULATION," THEN I BELEIVE IT'S THE DUTY AND RESPONSIBILITY OF LEGISLATORS WHO DON'T WANT REGULATION TO COME FORTH WITH THEIR PLAN TO REMEDY THE CRISIS WE NOW FACE.

THANK YOU VERY MUCH.

#2- 3-2-84

Health Care Expenditures
In Kansas
1966 to 1981
Department of Health and Environment

HIGHLIGHTS

Health care spending continues to be a major cause of concern in Kansas and the nation. Several trends underscore the importance of this issue:

* Kansans spent nearly $2.6 billion in 1981 for all health services and supplies, up 14 percent from 1980. This amounted to $1,079 per capita.

* 1981 health care spending contributed 8.9 percent of the Gross State Product, a slight increase over the 1980 share of 8.6 percent.

* Kansans spent $1,014 per capita for personal health care services in 1981, compared to $1,090 nationally. Per capita spending in Kansas is now 93 percent of the U.S. level; it was 96 percent in 1980.

* Kansans spent $491 per capita for hospital care in 1981, compared to $504 nationally. Hospital care accounted for the largest share, 48 percent, of 1981 personal health care spending in Kansas. Since 1975 the rate of spending for hospital services has grown faster in Kansas than the national rate.

* Since 1966 nursing homes have shown the most growth in health care expenditures nationally and in Kansas. Per capita spending in Kansas increased from $5.55 in 1966 to $101 in 1981, for an average annual increase of 22 percent.

* In 1981 $102.9 billion were spent for personal health services under public programs nationally, and $969 million in Kansas. Expenditures for these publicly funded services increased at an average annual rate of 26 percent in Kansas between 1966 and 1969. Between 1969 and 1981, these programs grew at an average annual rate of 14 percent. The Medicare Program contributed the largest share of public spending in Kansas amounting to $416 million in 1981. The ten percent increase in 1981 Medicare spending in Kansas was half the 20 percent increase experienced in 1980. The Medicaid Program contributed the second largest share of public funds amounting to $266 million in 1981.

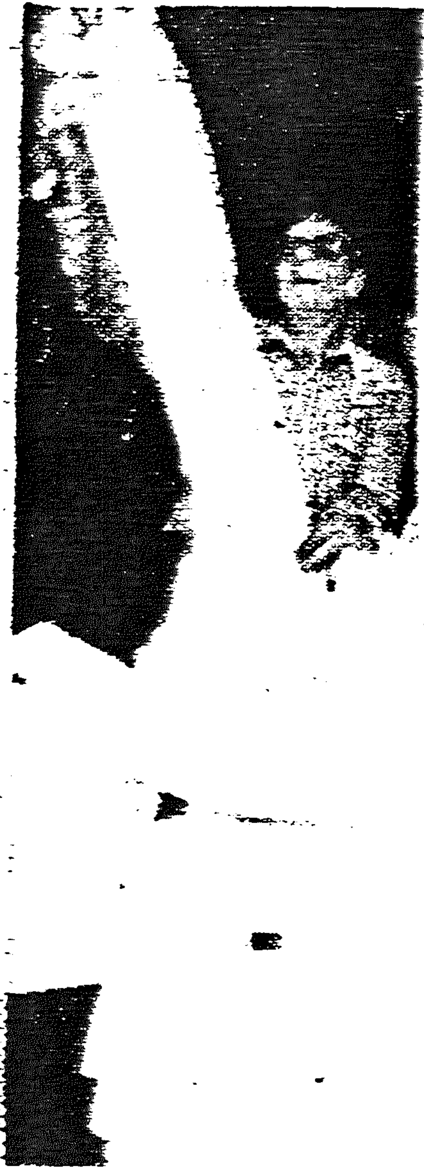
* The federal government funded nearly 30 percent of all personal health care services nationally and in Kansas in 1981, compared to only about ten percent in 1966. The federal government funded 41 percent of all hospital care nationally and 42 percent in Kansas in 1981.

* In 1981 out-of-pocket spending by consumers accounted for about one-third of all outlays for personal health care nationally and in Kansas, a notable decrease from the half contributed by consumers in 1966.

Atch. 2

The Wichita Eagle-Beacon
"Your Health Care Costs-Critical"
Jan. 29 - Feb. 2, 1984

Medical System Strains at Limits



Bill Youmans/Staff Photographer
Insurance covered most of Darrell Link's long bill for surgery.

Ahead in Series

- Monday: How doctors contribute to the price of care, which for the first time they must worry about.
- Tuesday: The hospitals, where most of the money goes, are under orders to run more like businesses.
- Wednesday: The insurers, who pay most of the cost, are pushing for lower bills.
- Thursday: The ethics of who lives, who dies and who gets care must be decided.

Benefits Make Surgery Viable

By Bob von Sternberg
Staff Writer

One day a little more than a year ago, the pain squeezed Darrell Link's chest.

"My father had that pain — the angina," he said. "They told him to take his pills and take it easy. That's all. A heart attack killed him."

As recently as 10 years ago, Link's fate probably would have been the same. But today, after a triple coronary bypass operation, the pain in Link's chest is gone.

His bill came to $30,279.10.

"WITHOUT THE surgery, he would have had a heart attack," said Link's wife, Millie. "My thought was: Will Darrell come through this and be healthy? It wasn't the money."

Only $308.74 came out of the Links' pockets after all the bills had come in from his doctors and Wichita's St. Joseph Medical Center. The rest was paid by Blue Cross & Blue Shield, thanks to a benefit from his employer, Southwestern Bell Telephone Co.

"I didn't worry about the money — I didn't even think of it," Link said.

He didn't have to.

LIKE MOST people, Link didn't have to worry about the money because his insurance policy paid his doctors and the hospital. Hospital officials had little reason to hold down their charges because they knew the insurance company would pay up. The doctors set their fees with the same assurance and were able to count on the hospital to give them all the equipment and space they needed.

Link's case isn't unusual, either. Every day, three open-heart surgeries are performed in Wichita; nationwide, more than 450 people a day undergo the operation.

Add up those operations, thousands of other surgeries, tens of thousands of tests, millions of days spent in hospitals, and the bill swells to hundreds of billions of dollars.

● MEDICINE, 9A, Col. 1

● MEDICINE. From 1A

PATIENTS, DOCTORS, hospitals and insurers have been riding the giant merry-go-round that the nation's health care system has become. As it spins faster all the time, no one has tromped on the brakes.

Until now, the insurance system — private and government — has done the most to keep it spinning, by raising rates and taxes.

But if something isn't done to finally apply the brakes, the fear is growing that the system may completely break down, sending its riders flying.

Last year — when that system cost $362 billion, up from $321 billion in 1982 — it was the first time health costs accounted for more than one-tenth of the gross national product.

CLOSER TO home, Kansans spent nearly $2.6 billion on their health in 1981 (the most recent figures available) — almost 9 percent of the gross state product. Put another way, $1,014 was spent on health for every man, woman and child in the state, compared with $1,090 nationally.

In Wichita, nearly 1,000 life-saving open-heart surgeries like Link's were performed in 1982. The price: at least $20 million, most of it covered by private insurers or the federal government. Nationwide, the 170,000 bypasses done in 1982 cost more than $3 billion.

Health costs have been increasing faster than inflation, devouring more tax dollars, employers' dollars and personal income every year.

AND OMINOUSLY, the push to force down medical costs could eventually run headlong into the aging of the American population.

The burden of aging already is falling on the Medicare system, as money spent in the last months of old people's lives consumes more than a one-quarter of the budget of the federal insurance program for the elderly. Last year, $12.5 billion was spent to treat the estimated 520,000 Medicare recipients who ended up dying during the year.

"We're in a classic rock and a hard spot," said Steve Harris, vice president for finance at St. Francis Regional Medical Center in Wichita. "What about a 75-year-old who needs a total hip replacement, a bypass and a kidney transplant — and he's going to live another year and a half? Do you spend $200,000, or let him die?

"IN AN impersonal society, we would make you comfortable but say you're too old, so you're not worth the resources. We don't want to make those decisions in the hospital. Who's going to?"

The costs, invariably described as "skyrocketing" for more than a decade, have slowly begun forcing radical changes on the nation's health care system.

If those changes — a new way of paying the bills — are successful, they will slow down the cost increases.

But no one has come up with a way to actually lower the costs.

THE NEW system of paying bills is setting the health care system on its head. Instead of paying doctors and hospitals whatever they charge, Medicare and Blue Cross for the first time have set binding limits on what they will pay hospitals.

"We've lost control of the costs, and that could break the system," said Harry Steinmeyer, former executive director for the southeast Kansas health planning agency. "It could fall apart. And no change will come until we change the reimbursement system."

The rush to change the bill-paying system is being led by the federal government as it tries to prevent the collapse of Medicare.

Close behind are private insurers who are losing customers — and money — because individuals and employers have begun to resist their continually rising premium costs.

IN KANSAS, the change has been more abrupt than almost anywhere else. On Jan. 1, Blue Cross and Blue Shield of Kansas, the state's biggest private insurer, adopted a system much like Medicare's. Blue Cross and Medicare account for 80 percent of the hospital admissions in the state.

The Medicare changes, which took effect Oct. 1, sped through Congress last spring on the heels of predictions that the Medicare fund would go broke by 1987.

Medicare spending has increased by nearly 30 percent in the past two years, to more than $56 billion last year. More than $32 billion went to hospitals, so the brakes were put on hospital charges.

BUT WHILE the overhaul in reimbursement may save almost $10 billion this year, federal budget analysts say that only buys time. The bankruptcy of Medicare, they say, has been staved off by no more than three years.

Blue Cross, which imposed the new payment system on the 148 general hospitals in Kansas on Jan. 1, hopes simply to survive. After losing 150,000 subscribers who have fled from its crushing rates, "we had to do some-

thing — or we weren't going be in business," said Marion Dauner, the Blue Cross official in charge of the new system.

"What Medicare and Blue Cross are doing isn't an attempt to cram anything down anyone's throat," he said. "It's the survival of the system. We're all trying to respond to what the public's saying: They can't afford it."

IF LINK'S heart had held up until a couple of years from now, he might have been discharged from the hospital sooner, or spent fewer days in St. Joseph's coronary care unit. His tests might have been streamlined, and some eliminated. Or he might not have had the surgery at all.

Traditionally, hospitals and doctors have been the price-setters of medicine. "Now, they're going to be price-takers," Dauner said. "All the providers are going to have to make realistic economic decisions, or they won't be there."

The providers have resisted the changes being forced on them, agreeing to go along only because to them, the new payment system is preferable to a more radical change — such as universal health insurance, guaranteed by the federal government.

THEY WOULD rather be left to themselves to control costs without outside interference.

"The only way we're going to accomplish savings is at the local level, what we're doing, not with a regulatory cookbook from the federal government," said Ivan Rhodes, a Wichita radiologist who heads a local organization that reviews doctors' practices to eliminate unnecessary treatment. "We're trying to achieve the same thing."

Doctors have long been the sovereigns of the medical system. They put people in the hospital, decide on tests and treatment and charge their own fees — in all, responsible for nearly three-fourths of the dollars spent on health care.

"PEOPLE ARE saying all we want to do is protect our own turf," said Terry Poling, a Wichita family practitioner and president of the Medical Society of Sedgwick County. "Hell, we know we've got to do something about costs."

Physicians generally are far more satisfied with the medical system than anyone else. That attitude was confirmed in a Harris poll last fall; two-thirds of the nation's doctors think the health care system "works pretty well," and doesn't need a major overhaul.

But three-fourths of the public thinks major changes are needed, as radical as a complete restructuring of the system, according to the survey.

AT THE same time, the pollsters found "a remarkable acceptance" by the public of cost-controlling tactics, even those that would increase their out-of-pocket expenses.

Another nationwide survey, conducted last fall for the American Association of Retired Persons, found that almost three-fourths of the public favors cost controls in the system — and that four out of five favor a limit on doctors' and hospitals' charges.

Kansans' total health bill could be lower if doctors did not put their patients into hospital beds more often than physicians elsewhere.

Compared to national averages, Kansans spent one-third more days during 1982 in the hospital and were admitted 46 percent more often.

DOCTORS AND hospital officials blame the age of Kansans for the higher hospitalization rates, while insurers point the finger at the doctors' practice patterns — and the fact that excess hospital beds in Kansas encourage hospitalization.

The new payment systems, along with public pressure to lower medical costs, are squeezing physicians to practice "cost-effective" medicine.

"Before about five years ago, cost wasn't a concern," said Kay Clawson, executive vice chancellor of the University of Kansas Medical School. "You were trained to order anything and everything. We never mentioned it."

Now, the cost of a test or a procedure is routinely mentioned to resident physicians as they make their rounds. While older physicians say they slowly have become more aware of costs, they feel shoved in the opposite direction.

THEY ORDER more tests, and more costly tests, than are medically necessary in part because they are afraid of being sued for millions of dollars.

"There's a tremendous squeeze on you," Poling said. "You want to cut costs, but you want to cover every possible eventuality in case of a malpractice suit. Attorneys say it's good medicine, but it's costly."

So costly, the doctors say, that the growing number of malpractice cases and mushrooming jury awards should get much of the blame for high medical costs.

Physicians' malpractice insurance premiums cost anywhere from $2,300 to $12,000 a year — up from $100 or $200 a generation ago. The average size of awards to plaintiffs has more than quintupled in the past decade. In Kansas, the number of malpractice awards of more than $100,000 has increased by more than 300 percent since 1977.

SO THE doctors practice what they call "defensive medicine," which the American Medical Association calculates cost $15 billion in 1982.

More pressure on the doctors: Under the new reimbursement setup, hospitals will lean on physicians to keep their costs down. Unnecessary tests or unjustifiably long hospital stays won't be paid for by Medicare or Blue Cross and patients can't be billed for any excesses.

"The new system puts the hospital in an adversarial position with the physicians," said Lee Baker, administrator of Wichita's Riverside (formerly Osteopathic) Hospital. "We have to watch their practice — and you don't change their practice patterns overnight."

THE STATE'S general hospitals face an economic ultimatum: Keep their charges below the insurers' limits or lose money.

"It's probably the most difficult time ever to run a hospital," said Walter Wentz, chairman of the health administration and education department at Wichita State University. "Cost has become the No. 1 issue."

Dick Morrissey, the state official who oversees Kansas hospitals, said the new reimbursement system "will force them to really look at their operations for the first time. Under the old system, they couldn't lose money."

Under the new system, hospital administrators will try get patients in and out as quickly as possible while trying to boost their admissions — a neat trick for most Kansas hospitals.

"IF YOU keep your occupancy at 80 or 85 percent, you can operate quite comfortably," Wentz said.

Kansas hospitals operated in 1982 at an average occupancy rate of 70 percent; nationwide, the average was 77 percent. In Wichita, only Wesley Medical Center had an occupancy of more than 80 percent.

And in the small towns and rural parts of the state, some hospitals have been struggling to keep half their beds filled.

"We couldn't be financially stable with that kind of occupancy," said Jon Boller, administrator of Susan B. Allen Hospital in El Dorado, where a 50 percent occupancy rate forced the firing of one-eighth of the employees and removal of one-fifth of the beds.

SMALL HOSPITALS, which are most of those in Kansas, could have an especially tough time under the new insurance payment system. Along with low occupancy, most lack sophisticated management and purchasing power enjoyed by larger hospitals.

"Not too many hospitals are doing well," Morrissey said. "They don't have enough patients. Rural folks are going to have to make a decision whether they want to subsidize their small hospitals. Even where there are too many beds, local folks don't want to give up their hospital. It's like a local school."

Too many beds pushes up medical costs, while acting as a financial drag on hospitals.

And there are too many hospital beds in Kansas. As a rule of thumb, federal guidelines say that fewer than 4 beds for every 1,000 people is enough. In 1982, there were 4.4 beds for every 1,000 Americans, 5.8 beds for every 1,000 Kansans.

AS THE state's health plan puts it: "Beds beget patients." Because of staffing and overhead costs, an empty bed costs a hospital one-half to three-fourths as much as a filled bed — without a patient bringing in revenue.

Hospital administrators don't like to get rid of beds any more than they want to quit offering medical services that drain them financially.

"But they're going to have to start asking themselves what services they can afford to offer if the community isn't using those services," Wentz said.

The new payment setup may force such decisions, accelerating trends that are reshaping the hospital industry. Hospitals probably will specialize in certain fields, such as minor emergency care, more than they have in the past. They will huddle under corporate umbrellas that save them administrative costs. Kansas' non-profit hospitals — meaning all but two of them — will continue to spin off profit-making corporate subsidiaries. They will lay off employees. They will compete, with ads and promotions, more than ever.

AND SOME hospitals probably will be forced to shut down.

"I wouldn't be surprised to see some of ours close in the next year," Morrissey said. "I would be if it's a large number."

When pressed to explain their rising costs, doctors and hospital officials blame patients as the ultimate culprit.

"If the patient was paying the bill, economic decisions would be made," St. Francis' Harris said. "When the patient isn't paying, the whole system breaks down."

The doctors and officials say they are simply giving their customers what they want and what the customers want is everything available.

"PEOPLE HAVE an insatiable demand for health care," said Bob O'Brien, executive vice president of the Wesley Corp., parent of the medical center. "We merely were responding to that desire."

That meant building beds that ended up not being needed, performing the procedures people wanted and scrambling to obtain the technology that could perform tasks that would have seemed like miracles a generation ago.

And it was all paid for, by the insurers — and only indirectly by the patients, through their insurance rates and their taxes.

According to the state's health plan, there is "literally no relation between cost and the consumer's decision to seek care, nor the physician's desire to obtain care."

Wichita Eagle Beacon
1-29-84

Checkbooks Suffer As Cures Improve

By Brian Settle
Staff Writer

Ten years ago, the average charge for a semiprivate room in a Kansas hospital was $44 a day.

Today, a day in the same room costs at least $144.

From blood tests to baby deliveries, from drugs to a day in the hospital, health costs have shot up like a thermometer inside a hot oven.

- The price of a day's antibiotic treatment has increased from $2 to anywhere from $100 to $200 in some cases, according to hospital pharmacists.

- The average stay in a Kansas hospital today — 5.9 days — costs $2,188.07, up from an average of $568.50 in 1973.

- A blood test at a Kansas hospital costs around $20, up from just more than $10 at most hospitals 10 years ago.

- Having a baby today costs an average of $3,702, up from less than $1,000 10 years ago.

THE INCREASING costs add up. The consumer price index, which measures the average change in prices for products bought by urban wage earners based on 1967 costs, shows the meteoric rise of health costs.

Like everything else, health costs have increased in the past decade. But health costs have increased faster than any consumer commodity except energy.

At the end of 1973, the CPI for medical care was 137. That means health care that cost $100 in 1967 cost consumers $137 in 1973. But by mid-1983, consumers were paying $358.

● ECONOMICS, 8A, Col. 1

Doctors, Hospitals Point at Each Other and System

● ECONOMICS, From 1A

OTHER COSTS went up too, of course. But health care stands out. For example, the CPI for food in 1973 was 141, compared with 283 in 1983.

The reasons are as widespread as the increasing costs. Doctors attribute the costs on advanced technology and the defensive medicine they practice to head off malpractice suits. Hospital officials point to higher salaries for nurses and other health professionals, in the same breath blaming doctors who have no incentive to cut costs.

But all agree that something needs to be done to contain the cost of medical care.

According to Tom Miller, vice president of Blue Cross & Blue Shield of Kansas, the daily patient charge in a Kansas hospital in 1973 was $95 a day.

"BY 1982," Miller said, "the average daily cost was $370 a day. When you multiply the average time a person stays in the hospital (5.9 days), that comes out to $2,183 per person per stay. You can see that's a lot of money."

While the average cost of a hospital bed has increased by more than $100 in 10 years, ancillary costs have shot up even more, health officials say.

"Ancillary costs are anything besides what the room costs," Miller said. "That includes such things as blood profiles, drugs, those types of things."

Even the simplest medical care in a hospital costs more today.

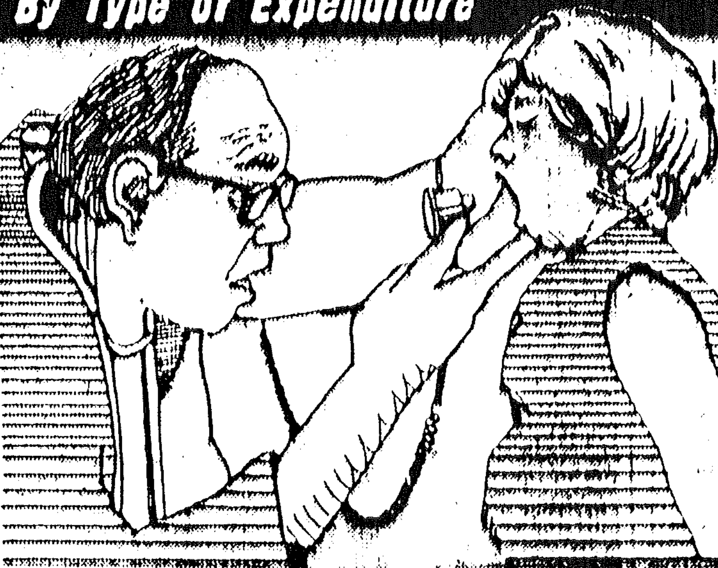
"A COMPLETE blood-count test today costs $19," said Edd Beals of Wichita's St. Joseph Medical Center. "Our available files go back only to 1978, when it cost $13."

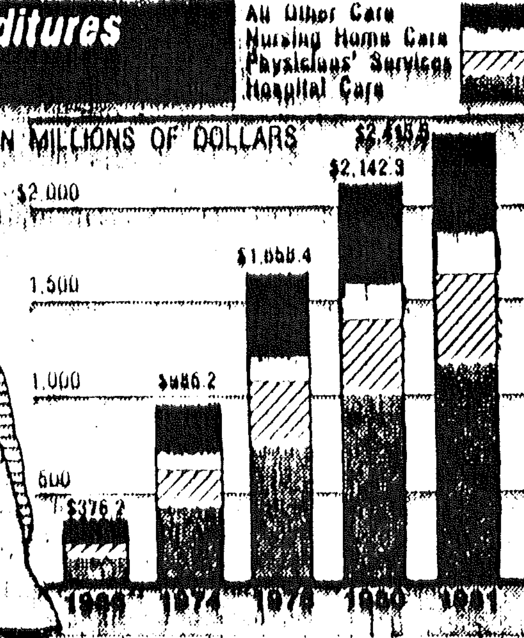
But the machine St. Joseph's uses to test blood counts, Beals said, "cost $20,000 in 1978. Now it costs $100,000."

Even the price of drugs — long a stable cost in the health profession — has gone up.

"For quite some time," said Ken Schafermeyer of the Kansas Pharmacists Association, "prescription drugs have not increased in price. Drugs come on the market very expensive and decrease as they stay on the market."

Kansas Personal Health Care Expenditures By Type of Expenditure





Source: Kansas Department of Health and Environment — Cynthia Greer/Staff Artist

BUT THAT changed in the last couple of years, said Schafermeyer.

"We had a great number of new products, much more specific products, and much more cost effective in the long run. But that has increased the overall average of drug prices, and that changes a 25-year trend."

One of the "more specific products" is expanded spectrum penicillin. And it's a good example of the advanced technology of drugs and the high price that hospitals, patients — and, ultimately, insurers — pay for the technology.

"The new drugs are really expensive," said Pack LaMont of the pharmacy department at St. Joseph. "Especially some of the antibiotics. It used to be you gave a patient some penicillin for $2 a day and sent him off. But now it can cost anywhere from $100 to $200 a day for antibiotics alone."

ANOTHER REASON for the increased cost of drugs is the way they are administered, LaMont said.

"It used to be you administered it with a needle. Now, many drugs are administered intravenously, and you pay for the bottles, the needles ... it all adds up."

The reason the more expensive drugs are used, LaMont said, is "that's what doctors are prescribing. They don't have to worry about costs."

THEY DO now, and so do hospitals, now that Blue Cross and Medicare have changed the way they pay bills.

Hospitals — and most doctors — now accept fixed payments from insurers. If they spend more than the amount, they they can't turn around and bill the patient, but must absorb the extra cost.

The new payment system and increasing costs of medicine have changed the way medicine is viewed on the stock exchange, where it has long held a blue-chip reputation.

"What we're seeing now," said Jeffrey Suebel, an industry analyst for Kidder-Peabody and Co. in New York, "is very much insecurity in the market toward the health industry. People know there are changes coming; they're just not sure what they will be."

AND MINOR care centers are becoming the rage on the stock market, said Bill Goodwin, an Iowa-based industry analyst for R.G. Dickinson & Company Inc., which has an office in Wichita. "The feeling is that's where medicine is headed, that these places can get you in and out faster and more efficiently while providing the same services as hospitals."

In Wichita, for instance, St. Joseph has taken the lead in that market with its three minor emergency centers. And Wesley Medical Center operates a minor surgery center.

The increase in hospital costs resulted from "a lot of reasons," said Miller of Blue Cross & Blue Shield.

"Medical technology increased considerably in the last 10 years," he said. "They were doing very few open-heart surgeries in 1973. Today, it's fairly common. You throw in one expensive, complicated procedure like that, and it has an impact on the overall cost. And that's just one procedure."

DOCTORS POINT to an increase in the use of services and defensive medicine because of malpractice lawsuits.

"Physicians feel they have to run tests to protect themselves. So that shoots up ancillary costs because there are more tests," Miller said.

The increased amount of money paid in salaries is another reason costs are higher, Miller said.

"During the late 1970s and early 1980s, it really went up. There was an extreme competition for registered nurses during that period, for example, and that resulted in tremendous salary increases."

IN 1982, the four Wichita hospitals were second only to Boeing Military Airplane Co. as a source of jobs in Wichita. The hospitals — St. Joseph's, Wesley Medical Center, St. Francis Regional Medical Center, and Riverside Hospital (formerly Osteopathic) — paid $188.5 million in salaries and benefits to their more than 8,800 full- and part-time employees.

But Miller and others think the increased national concern and the changes that result about the cost of medical care will stabilize the cost of medical services in the coming years.

"We're headed in the right direction," Miller said. "I think we're on the road to restraining costs."

Insurers Take Aim at Rising Bills

New Payment Systems Devised

Small change was all that Darrell Link had to take from his own pocket to pay off his heart surgery bill. Nine-tenths of all hospital charges are paid for either by insurance companies or public assistance. But it wasn't free, even for Link. He, like all employees, employers — all taxpayers, in fact — pays the nation's exploding medical bills. Today's stories examine how the system of insurance has pushed up costs and how change may turn that around. Tomorrow: Who lives and who dies?

By Bob von Sternberg
Staff Writer

Even if Darrell Link's staggering medical bills hadn't been covered by his health insurance policy, he thinks he still would have gone ahead with his heart surgery.

But paying his wad of bills, which totaled $30,279.10, probably would have forced him to sell his house in south Wichita.

"I guess I would have had to," he said, nearly a year after his successful triple coronary bypass. "Or I would have gone to the doctors and told them. Maybe I could have gotten a discount or something."

None of that was necessary.

Blue Cross & Blue Shield of Kansas paid nearly 99 percent of the tab, a benefit that is part of Link's lineman job with Southwestern Bell Telephone Co.

"I guess that's why doctor bills and hospital bills are so high," Link said. "You've got people who can't afford to pay, so people like me end up paying."

Not exactly.

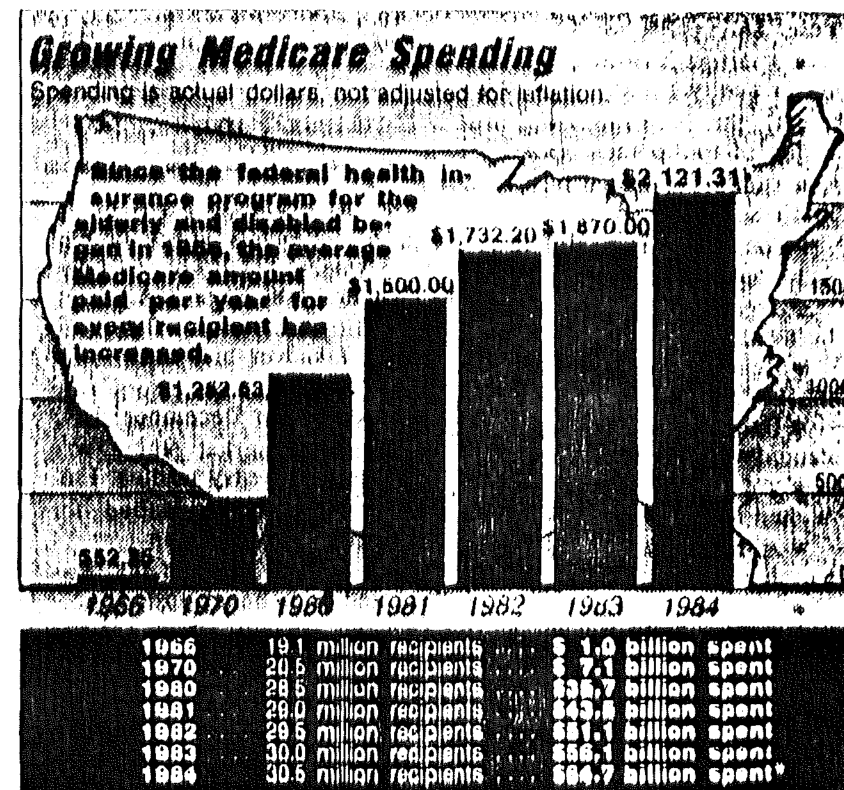
Like most people, Link couldn't have afforded to pay all of his bills if insurance had not shielded him from the real cost.

Indirectly, Link's bill was paid by Southwestern Bell, which picked up the premiums of his Blue Cross & Blue Shield policy. Health insurance costs the company an average of $180 a month for each of its 7,143 employees in Kansas, a total of $15.4 million.

Other people who pay part or all the premiums of their insurance feel the increasing health costs more directly.

And indirectly, Link — like all taxpayers — pays the cost of medical care for others who can't afford it, through the taxes that finance Medicare and Medicaid.

● INSURANCE, 8A, Col. 1



Source: Health Care Financing Administration *estimated
Cynthia Greer/Staff Artist

● INSURANCE. From 1A

Less than a third of all medical costs are paid out of patients' pockets. Nine-tenths of all hospital costs are covered by private insurance or public assistance.

Public and private health insurance has become so widespread that a recent Harris survey revealed that only 6 percent of the families in the nation — 3.9 million — said there had been times when they or someone in their families needed medical care but did not obtain it.

FIFTY YEARS ago, almost no one in the nation had health insurance. As recently as 1966, insurance took care of less than half of the bill.

"It's free money," said Harry Steinmeyer, the former chief public health planner for southeast Kansas. "Everyone wants health care, and they can afford it because they're covered.

"Whether it's private insurance or Medicare, you feel like you're getting some of your money back when you use the system."

Blank checks have been the legal tender of that free money.

No market mechanisms were at work to hold down charges. Generally, doctors and hospitals would be paid whatever they charged for their services. That pushed up costs because guaranteed reimbursement of their expenses encouraged them to do more procedures, buy new equipment and erect new buildings. Patients, whose bills were covered, pushed them to do all those things.

ABRUPTLY, AN upheaval has blasted through that system. The cost to most individuals may have been little or nothing but the cost to society overall has become huge.

Now, Blue Cross and Medicare, which insure almost 80 percent of the hospital bills in Kansas, have changed the way they pay bills.

In theory, the new reimbursement system will tear up the blank checks. Hospitals will have to accept fixed payments from the insurers. If they can do a procedure for less than the fixed amount, they make money. If they do it for more, they lose.

Patients will not bear the financial burden for a hospital that can't keep its charges within the limits, because hospitals are barred from charging patients for any excess.

IF HOSPITALS find they are losing money on their Medicare and Blue Cross patients, administrators said they probably would try to make up the difference from other patients — those who are insured by other commercial companies or people who have no insurance.

"That's the way hospitals have always done it," said Walter Wentz, chairman of health administration and education at Wichita State University. "Eventually, though, the other commercial insurers will say they don't feel it's fair to be charged a higher rate than Blue Cross, so they'll demand the same rate."

HE AND others predicted that the widespread move to the new repayment system in Kansas will create a domino effect, eventually inspiring other commercial firms to start charging the same way.

But no one knows how the new system will work. Physicians worry that pressure to hold down costs will hurt the quality of care they can give. Hospitals worry that the same pressure could cut into their revenue — and maybe put them out of business.

Some public officials fear that the doctors and hospitals will learn all too easily how to abuse the system — and end up making more money than ever.

FINALLY, AS big a change as the new system represents, it merely will slow down — but not lower — rising health costs. And payment levels may actually increase bills in some cases.

"Sure, you could bring insurance rates down dramatically — but you'd put hospitals out of business tomorrow," said Marlon Dauner, the Blue Cross vice president who is orchestrating the new payment system. "Insurers took the burden off the individual to be cost-conscious. This all tries to develop competition and instill the economic forces that work in the rest of the economy."

"Competition" has become a magic word in health care: The more competition that can be crammed into the system, the more savings that will result.

HOSPITALS throughout the nation have been living with the new reimbursement system since Oct. 1, when Medicare cases — about one-third of their patients — started to be paid under the new rules.

With the Medicare system tottering at the brink of bankruptcy last year, hospital costs were an obvious target. Almost two-thirds of the $56 billion spent on Medicare last year was spent in the nation's hospitals.

Blue Cross isn't facing bankruptcy and remains the biggest insurer in Kansas, but it has seen its subscriber ranks dwindle from almost half of eligible Kansans to a little more than one-third — a loss of 150,000.

"THE IMAGE of Blue Cross & Blue Shield is probably lower than it's been in our history," Dauner said. "When we lose 150,000 members, they are saying they don't like what we're doing."

As subscribers' employers have fled from Blue Cross, they have set up systems to insure themselves or signed up with health maintenance organizations, or HMOs, which keep rates low by discouraging expensive treatment.

The new Medicare and Blue Cross reimbursement setups are called "prospective" payment systems, that is, a rate is set before the work is done instead of the old system of paying a bill, however high, after the fact.

MEDICAL procedures have been turned into product lines under the new system. Everything — the cost of a hospital bed, drugs, tests, surgical rooms — is lumped together and the cost is added up.

More than 10,000 possible medical diagnoses are arrayed under 467 diagnosis-related groupings (DRGs) that describe disease, age, surgical procedures and complications.

For example, Darrell Link received DRG 106 — a coronary bypass with cardiac catheterization. Forty-two other DRGs describe diseases and disorders of the heart and circulatory system, from chest pain to amputation.

THE BOTTOM line — the amount a hospital will receive for each procedure — will differ, depending on whether a patient is covered by Medicare or Blue Cross, because the private insurer and the federal government calculated their charges in completely different ways.

Using Link's case as an example, St. Joseph Medical Center charged $20,943.60 for his heart surgery and an earlier catheterization of his heart a year ago, lower than the average for that procedure. Under the new Blue Cross DRG system, the hospital could have charged as much as $27,704.

IF LINK had been a Medicare recipient, the hospital would have been paid only $17,770. It would have been barred from trying to collect the difference from Link.

Sometimes Medicare is a better deal than Blue Cross for the hospitals, sometimes not.

For hospitals in Wichita, Blue Cross will reimburse up to $3,237 for simple pneumonia in an adult under 65 with no complications. Medicare will pay $3,325. If a patient with pneumonia has complications or is older than 70, the maximum charge to Blue Cross is $4,915; Medicare, $3,491. A hospital can charge Blue Cross up to $2,367 for an appendectomy, Medicare, $3,553. For a birth with-

out complications. Blue Cross will pay up to $3,020.

THE BLUE Cross reimbursement formula isn't as tough as it could be.

"We could have set it lower, but we'd bankrupt every hospital in the state," Dauner said. "If a hospital has consistently high charges, it's going to go broke. And we can't care about them."

Comparing the old system with the new one is difficult because Blue Cross does not know how much "average" hospital charges were, Dauner said. The company simply paid the total.

The reimbursement rates will differ depending on the size of the hospital: the larger the hospital, the more expensive. The average charge for the state's biggest hospitals — most of which are in Wichita — was $2.595.08 last year, more than double the average charge at the 72 smallest hospitals — $1.266.02.

UNDER THE Medicare system, if a hospital can do procedures for less than the DRG rate, it gets to keep the difference. Under the Blue Cross rate, a hospital will be paid its actual costs, up to the maximum. If it manages keep its charges under the maximum throughout the year, it will get a cash bonus at the end of the year.

All of the state's hospitals are required to follow the Medicare DRG system and have agreed to use the Blue Cross system.

For all the hoopla and worry surrounding the DRG system, Blue Cross's promises aren't grandiose. Instead of yearly rate increases of nearly 25 percent, the company hopes to keep those below 15 percent.

EVERYONE IS long on speculation because they are short on experience.

At Halstead Hospital, the Medicare DRGs "aren't too painful yet because they're still being phased in," said Administrator Richard Nierman. "But there are going to be problems."

For instance, he said, hospital officials have discovered that the DRG that covers replacement of clogged carotid arteries in the neck doesn't reflect the reality of the procedure.

"Usually, you do two, because both are usually affected," he said. "But with the DRG, you get paid for one even if the person needs both. You either do both and absorb the cost or discharge and readmit the patient — the person could have a stroke while they're gone. Or we could get audited for double-billing."

AS FOR the doctors, the American Medical Association last fall repeated its long-standing fear that "the program being considered had never been demonstrated and that there were serious questions" about the quality of care DRG patients will get.

But DRGs are too new to know what they will do.

In Oklahoma and Arizona, Blue Cross is trying the system as it is in Kansas. In New Jersey, an experiment with DRGs has been conducted since 1980.

The New Jersey trial has reduced the average hospital stay, but the financial savings — if any — still aren't clear, according to a recent study by the federal General Accounting Office.

BUT THREE years of DRGs have revealed several potential problems, identified by the GAO and Congress' Office of Technology Assessment.

According to the studies, the payment system encourages hospitals to boost their admissions while reducing the length of their patients' stay. Reducing patients' length of stay will save the most money, but will not be as much help for hospitals with already-low occupancy rates. And no one knows if patients will be satisfied with the system.

The new system can be undermined if hospitals use a "revolving-door" scheme, hospitalizing marginally ill patients, discharging them and readmitting them for a different ailment. Doctors can use DRG "creep" — diagnosing patients as sicker than they really are, drawing more reimbursement than the hospitals actually need.

WHILE THE OTA study said those deceptions are "easy for physicians to implement and difficult for third-party payers to control," officials of Blue Cross and the state's hospitals said too many double-checks are built into the DRG system for it to be easily manipulated.

DRGs aren't the only alphabetical innovation sweeping health care in an attempt to rein in costs.

Along with HMOs, preferred provider organizations, or PPOs, are popping up around the country — setups in which physicians and hospitals agree to hold their charges down in exchange for a guaranteed flow of business. Businesses promise to send their insured employees to a PPO in exchange for the guaranteed discount rates.

The Blue Cross & Blue Shield organization that serves the Kansas City metropolitan area is experimenting with the PPO idea, its only appearance so far in Kansas.

PAYING THE BILL

HOSPITAL REIMBURSEMENT

"Typical" charges for hospitals during 1983 are not available because each hospital's fees differ so widely. Some charged more and some charged less than the new maximums.

Figures show differences in reimbursement to hospitals under new diagnosis-related group (DRG) system. Blue Cross pays up to the listed amount. Medicare pays the amount listed. All figures are for 1984 Wichita market. Reimbursement at hospitals elsewhere in Kansas probably will be lower.

DIAGNOSIS	Blue Cross	Medicare
Coronary bypass, with cardiac catheterization	$27.704	$17.770
Pneumonia and/or pleurisy age 18 and over (or over age 70, and/or with substantial complication)	$4.915	$3.491
Pneumonia and/or pleurisy age 18 and over (or under age 70 without substantial complication)	$3.237	$3.325
Tonsillectomy and/or adenoidectomy under age 18	$1.319	$1.065*
Appendectomy without complication under age 70	$2.367	$3.553
Delivery of baby	$3.020	not applicable

PHYSICIAN REIMBURSEMENT

Figures show maximum Blue Shield reimbursment to physicians in Kansas.

	1983	1984
Triple coronary bypass	$3.100	$3.100
Appendectomy	$583	$550
Baby delivery plus total obstetrical care	$642	$640

* over age 18

Source: Blue Cross and Blue Shield of Kansas

B h Rosenberg
St... ...ier

When Larry Griffie recently took his 2-year-old daughter to a free medical clinic for her cold and high fever, the unemployed worker hoped to head off the pneumonia and croup that hospitalized the child last year.

Before he found out about the clinic, sponsored by the United Methodist Church's Wichita Urban Ministry, Griffie and his wife, Margaret, tried to treat their children's illnesses at home.

"If it gets to the point that we have to get help, we go to the emergency room," said Griffie, a father of three who has been without work since July 1981. "Right now, we can't afford to do that. We haven't paid off the (previous) bills yet. It's hard to pay off anything."

WITH RENT, food and utility bills to pay, the family of five scrapes by on $680 a month that Margaret Griffie takes home from her job with the state Department of Social and Rehabilitation Services.

Although she's covered by medical insurance through her job, the rest of the family isn't. They can't afford the extra $109 monthly premium for family coverage. And the family makes too much money to be eligible for government medical assistance.

The Griffies, like many others throughout the United States, are caught in a Catch-22 situation. They don't earn enough money to afford health insurance, yet they earn too much money or have too many assets to qualify for a government medical program, such as Medicaid and Medikan.

IN A 1982 Harris survey, about 6 percent of the families in the United States — representing 3.9 million families — said there had been times during the previous year when they or someone in their families needed medical care but did not obtain it.

More than half of those people said they did not even try. The rest tried to obtain care and failed — about 1 million families had at least one member who was refused care for financial reasons, a figure that includes members of 208,000 families that had no insurance.

Many of the uninsured are the newly poor, recently laid-off workers who used to be covered by comprehensive policies through their employers. Others are struggling to get by on minimum-wage jobs because they couldn't find a better-paying job or lack the skills to qualify for one.

STILL OTHERS are too sick to work regularly, but not sick enough to qualify for disability benefits. Or they may be uninsurable because of existing medical conditions that make them high risks for insurance companies.

In Wichita, at least, the problem isn't as great as it was a year ago, when large lay-offs at the aircraft companies put Wichita unemployment at 9.6 percent. Less than a year later, the November unemployment rate dropped to 5 percent.

"Compared to a year ago, the pressure is less," said Terry Poling, president of the Medical Society of Sedgwick County. "We were frightened about the implications of the problem a year ago. We don't see it as as much of a problem now."

ALTHOUGH IT'S difficult to determine how many people fall through the cracks when it comes to health insurance, there are indications that many people still have difficulty paying for medical care. For example:

- Of the 500 people who went to the United Way of Wichita-Sedgwick County Emergency Center for Laid-off Workers in December, 274 said they had no medical insurance. During 1983, the United Way center paid about $2,300 for prescription drugs.

- The Medical Services Bureau, sponsored by the Medical Society of Sedgwick County and the United Way, helped nearly twice as many people in 1983 over 1982. Last year, they helped 2,880 people, compared with 1,536 people in 1982. The bureau primarily helps low-income people pay for eyeglasses and prescription drugs.

- In December, of the 198 people who applied only for medical assistance from the Wichita office of the state Department of Social and Rehabilitation Services, 117 people received help. Generally, officials say, about 75 percent of those who apply for any type of general welfare assistance qualify.

- A free medical clinic, sponsored by the United Methodist Urban Ministry, has treated 600 patients in Wichita and Hutchinson since it opened 10 months ago.

- Overall last year, Wichita's four hospitals spent $14.1 million for charity care and people who couldn't pay their debts. That figure amounts to 4 percent or 5 percent of each hospital's yearly budget. St. Joseph Medical Center, for example, spent $1.46 million on charity cases in 1983, about $1 million more than in 1982, and another $2.71 million in bad debts.

SOME LOCAL programs started in the past year have helped to ease the crunch for many people. For example, the Sedgwick County Medical Society last year began a program to help laid-off workers. Nearly 400 doctors agreed to see them and their families if they were referred through the Medical Services Bureau.

Limited services, such as inoculations, are available through the Wichita-Sedgwick County Department of Community Health, and through a free clinic sponsored by United Methodist's Urban Ministry.

For families such as the Griffies, the help is particularly important. When the Griffies sat down to figure out whether they could afford medical insurance for their entire family, the decision didn't just involve prescriptions and doctor's visits. It came down to a matter of survival.

As a minor, John Coleman received medical help through a state agency. But those benefits ran out when he turned 21.

ABOUT HALF their income pays the rent, with at least another 15 percent going for utilities. They also owe about $2,000 in hospital bills from their daughter's illness last year.

"We need it (insurance) and everything," said Larry Griffie, 34. "But the immediate things came first. I had to look at feeding them and clothing them.... It was a hard decision. We really need the insurance. If something were to happen to us, we'd be in a bad fix. We're in a bad fix right now."

Griffie received help last month from the free clinic run by Carolyn and Marvin Piburn, medically trained Methodist missionaries who take care of patients three days a week at St. Paul United Methodist Church in Wichita and one day a week in Hutchinson. Later this month, the Wichita clinic will be moving to Cathedral Apartments at Central and Broadway.

CAROLYN PIBURN said about 10 percent of the patients they see have no insurance.

"We see a good many people who can't afford to pay doctors," she said. "Many are having trouble even buying their medicines. I think that it is a serious problem. It may have let up a little bit in past couple months, but not overly so for the hard-core people having problems."

John Coleman is one of those people. Born with birth defects, including one ear, a cleft palate and curvature of the spine, Coleman had an operation every year until he reached age 20. Before he turned 21, he received medical help through Kansas Crippled and Chronically Ill Children's Services.

NOW 23, he hasn't been able to get medical insurance because he can't afford the high premiums and his existing medical problems would not immediately be covered. Although he has applied for government medical assistance, he was turned down because his $5.75-an-hour job as a trim carpenter puts him over the income guidelines.

In addition, he recently had surgery for problems arising from an auto accident three years ago. He also plans to have further surgery this month because of problems with his teeth. His mother estimates he owes St. Francis Medical Center about $3,000, which he plans to pay back a little at a time.

"THEY CAN'T throw you in jail for making an effort," Coleman said. "All you can do is pay a little at a time. Since I have medical bills, I don't have money for insurance. It's not really worth it. The insurance would cover very few things. Why pay for something you can't use?"

Said his mother, Annie Coleman: "There's no help out there. If it ever gets to the point that no doctor will take you, I don't know what will happen. The first question doctors ask is 'How will you pay?'"

Bill Youmens/Staff Photographer

Larry and Margaret Griffie have made tough decisions about care for their children: Larry, 8; Tressie, 6; and Tiare, 2.

Through the years, many hospitals accepted a certain number of charity cases through the Hill-Burton plan, a post-World War II program that gave hospitals building money in exchange for accepting patients who couldn't pay for treatment.

ST. JOSEPH, for example, must provide $300,000 a year in free care as the result of using $804,000 in Hill-Burton money between 1961 and 1976. The hospital spends $1.16 million more than that in free care. About 5 percent of the hospital's $78 million budget is spent on charity care and bad debts.

Wesley Medical Center is the only other Wichita hospital that received Hill-Burton money. And on the first day this year that applications were accepted, the hospital had requests for $140,000 from people without any insurance. Although the hospital is required only to spend $112,662 a year through the program, the hospital accepted the additional applicants and has another $90,000 in requests pending.

HOWEVER, NO Kansas hospital turns away patients who are unable to pay, according to the Kansas Hospital Association.

"We don't want to see the people who truly need care turned away and not getting it," said Ken Schanz, director of patient accounts at St. Francis. "We feel that's part of our responsibilities to the community."

But Schanz said those people without insurance aren't even the greatest number of charity cases at the hospital. For instance, he said, many people have insurance but find out they aren't covered because of pre-existing medical problems. Others can't afford to pay the share of the bill that insurance doesn't cover.

Eagle-Beacon 1-31-84

A $7.90 Valium tablet was only one of hundreds of items that contributed to Darrell Link's $30,000-plus heart surgery bill. Most of the charges came from the hospital — and most of the dollars flowed back to the hospital, paying for staff, equipment, energy and a host of other items. Today's stories show how and why such charges have grown and how pressures are mounting on the hospitals to rein in their prices. At the same time, hospitals — in Wichita and rural Kansas alike — try to cope with rising operating costs, too few patients and income limits. They are experimenting with management while trying to reshape their relationship with the physicians who are vital to their survival.

Pressures, Costs Rising

Hospitals Struggle to Avoid Fiscal Crisis

By Bob von Sternberg
Staff Writer

When Darrell Link needed heart surgery last winter, he had three Wichita hospitals to choose from. Because his doctors wanted him to go to St. Joseph Medical Center, that's where he ended up.

He and his wife, Millie, never gave it a second thought. "Shop? For a hospital?" Millie Link said. "You can shop for clothing maybe, but not a hospital."

"You might find a cheap one," her husband said, "but you won't get the care. They've got labor, materials to worry about. If they can't make money, they can't keep their heads above water."

IN FACT, hospitals are finding it tougher and tougher to keep their heads above water, even though their revenue has been jumping by as much as 20 percent every year.

And, Millie Link's skepticism notwithstanding, major changes in health care may push patients into shopping for their hospital to save money.

When Link's medical treatment finally ended, more than two-thirds of his $30,279.10 bill came from St. Joseph — everything from $1.05 for a pain pill to $2,760 for an operating room.

Overall, 45 cents of every dollar spent on health care in Kansas goes to the state's 148 general hospitals.

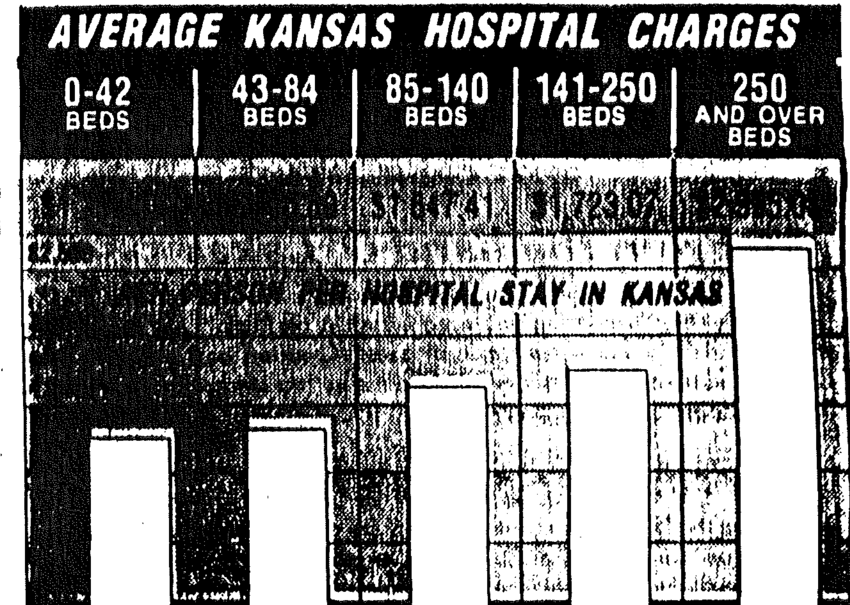
"THIS HAS become a big business," said St. Joseph President Joseph Heeb. "And we've got the same pressures that are on all big businesses."

Those pressures — increased competition, high costs, customer dissatisfaction — come at a time when the rising cost of health care is moving toward a political crisis.

"We all thought we were heading off the crisis on our own," Heeb said.

Unimpressed with the industry's cost-trimming efforts, government regulators, insurers and business leaders have been leaning hard on administrators.

● PRESSURE, 8A, Col. 1



Source: Blue Cross and Blue Shield of Kansas

Cynthia Greer/Staff Artist

Mounting Pressures Incre

● PRESSURE, From 1A

FOR THE first time, hospitals have an incentive to hold down their costs. No longer will most of their charges — however large — be paid automatically by insurers.

"It used to be there wasn't any financial reward for doing a good job," Heeb said.

The coming years "are going to be a ruthless, knockdown period," said Jeffrey Seubel, a New York-based hospital industry analyst for Kidder, Peabody and Co. "There are drastic changes occurring in the industry, and we're going to have some losers."

Some Kansas hospitals are desperately scrambling not to be one of the losers. Unable to fill their beds, many have been losing money. Some are shutting down the empty beds and laying off employees.

THEY ARE competing like never before, trying to sell themselves as specialists in money-making medical techniques. They even are beginning to think about cutting out some services.

"Hospitals simply can no longer be all things to all people," Seubel said.

During the past 18 years, hospital costs in Kansas have increased by more than 13 percent a year, faster than the nationwide increase.

And hospital costs have consistently outstripped general inflation. A study by state officials found that less than two-thirds of the increasing cost during the late 1970s could be traced to inflation; most of the rest was attributed to expanded service and escalating cost of care.

DURING MOST of the nation's history, hospitals were little more than death houses for people who couldn't afford personal physicians.

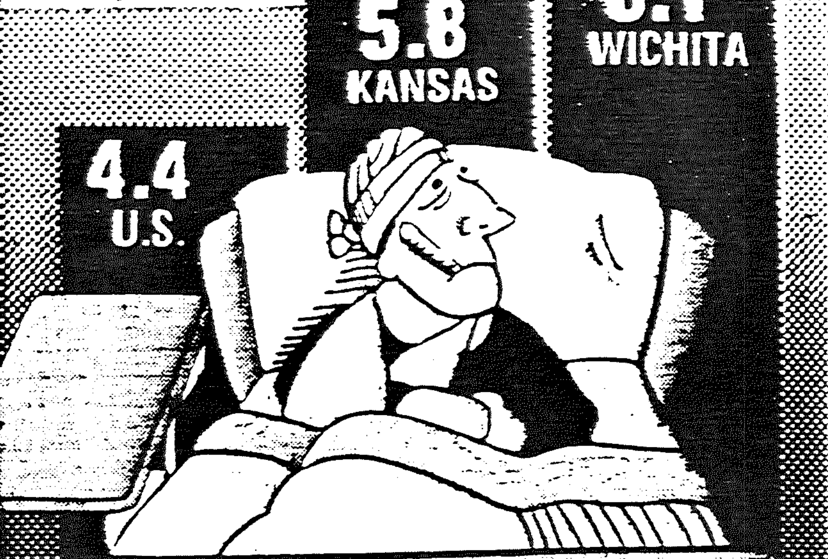
The explosion of the hospital industry — and hospital costs — came after World War II, when Congress came up with the Hill-Burton program. It was a huge boost to hospital expansion: $3.7 billion in federal grants for hospital construction and another $9.1 billion in state and local matching money. Most hospitals in Kansas were built or expanded with that money.

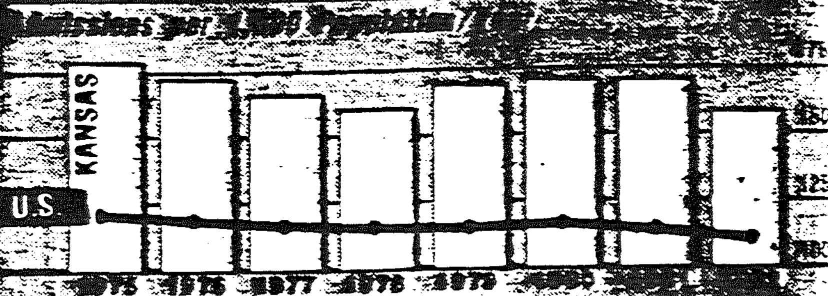
The number of hospital beds in America increased from 117,000 at the end of the war to 1.3 million in 1982.

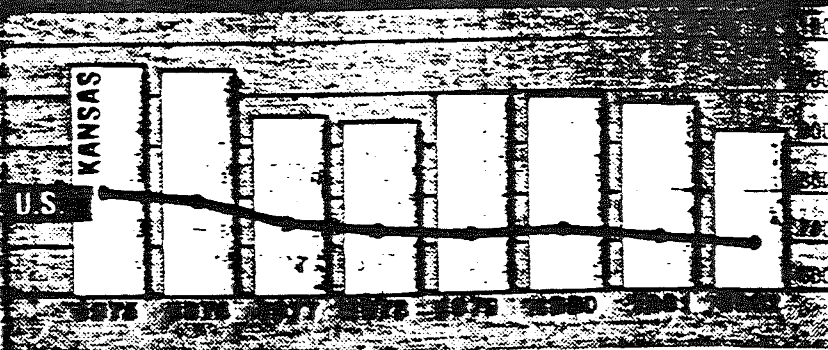
DURING THE same period, medical research, paid for by pharmaceutical companies and — for the first time — the federal government, yielded new procedures, drugs and machinery that insured patients could afford.

Another federal boost came in 1966, with the creation of the Medicare and Medicaid health insurance programs. For the first time, payment was assured for old people, who generally need more care than the population at large.

"The demand was unbelievable — for new facilities, new techniques," said Bob O'Brien, executive vice president of the Wesley Corp., which operates Wesley Medical Center in Wichita. "The government said build. Nobody had any idea the momentum was going to slow, that people would say we can't afford it."







Sources: Kansas Hospital Association, American Hospital Association, and Blue Cross and Blue Shield of Kansas

Cynthia Greer/Staff Artist

BY THE end of the 1970s, it was clear there were too many beds and not enough patients. As a rule of thumb, federal guidelines say that fewer than 4 beds for every 1,000 people is enough. In 1982, there were 4.4 beds for every 1,000 Americans.

The ratio was even worse in Kansas, where 13,593 beds equaled 5.8 beds for every 1,000 Kansans.

One reason is that in addition to the hospitals in medium and large cities, scores of tiny hospitals are scattered throughout the lightly-populated rural areas of Kansas. As a result, the average hospital in the state has only 90 beds, small by industry standards.

Hospitals in Kansas and other states got an additional helping hand to expand.

THROUGH THE end of 1982, local governments across the state had issued $412.6 million in industrial revenue bonds from local gov-

...ease Medical Competition

ernments to build and renovate 104 hospitals, laboratories and medical buildings. That was nearly one-seventh of the IRBs issued in Kansas. In Wichita alone, $144 million has been funneled to the four hospitals and a few clinics.

At St. Joseph in Wichita, the $24.5 million in IRBs given to the hospital "have made possible our expansion," Heeb said, making it affordable.

But being able to build a hospital doesn't guarantee that it can be operated in the black.

And the new insurance reimbursement systems — affecting more than three-fourths of the hospital admissions in Kansas — could make it even tougher.

ON OCT. 1, Medicare changed the way it pays bills. Hospitals were told they would have to accept a lid on payments for each procedure, whether or not it covered their costs.

Blue Cross of Kansas dropped the other shoe Jan. 1, when it adopted a similar payment system, making Kansas hospitals one of the nation's guinea pigs of the new reimbursement system.

Under the old system, Darrell Link was sent home from St. Francis 12 days after he entered the hospital. He was a satisfied customer.

"The care I got was excellent," he said. "You'd ring for them, and they were there. They were super. And I've never seen so dang many doctors in my life."

WITH THE new reimbursement system, Link likely would have been out of the hospital sooner and his nursing care might not have been as intensive, administrators said. St. Joseph charged $20,943.60 for his heart surgery and an earlier catheterization of his heart a year ago, lower than the average for that procedure. Under the new Blue Cross system, it could have charged as much as $27,704.

Hospitals such as St. Joseph that charge less than the maximum will get a financial bonus for doing so.

A hospital that fares well under the new system will increase its admissions — especially in medical specialties that don't cost it money — while keeping the length of its patients' stay down. At the same time, it will be under the gun to keep down its administrative and employee costs — at least two-thirds of a hospital's budget.

"UNDER THE old system, a hospital couldn't help making money," said Ron Smiley, manager of Medicare reimbursement in Kansas. "You didn't have to think twice, because you were assured of having your costs covered. If the docs wanted a new CT scanner or new surgical tools, no problem.

"Now you want to get the patients in and get 'em out as fast as you can. Do that, and you'll have money in the bank."

The recent history of Kansas hospitals shows that many are in a shambles — even without the complication of the new payment system. It also shows that for all the price-setting latitude they enjoy, a lack of patients can be disastrous.

Ahead in Series

- Wednesday: The insurers, who pay most of the cost, are pushing for lower bills.
- Thursday: The ethics of who lives, who dies and who gets care must be decided.

IN EL DORADO, at Susan B. Allen Memorial Hospital, 35 of the hospital's 280 employees were laid off last summer and 23 of its 103 beds were shut down. Administrator Jon Boller hopes state law will change to allow him to use those beds for less expensive long-term nursing care.

"It's better to be a strong 80-bed hospital than a weak 100-bed hospital," Boller said. "Everybody's going to have to take a real hard look at their overhead costs."

Employees also have been recently laid off at Mt. Carmel Medical Center in Pittsburg, St. Francis Regional Medical Center in Wichita and Labette County Medical Center in Parsons. Hours, pay and some services have been cut at St. Joseph Memorial Hospital in Larned.

MOST HOSPITALS have avoided the outright elimination of beds, as occurred at Allen Hospital, but many have quietly quit staffing some of their beds to save money.

Occupied beds are critical to a hospital's health; an average occupancy rate of 80 percent is considered necessary to operate comfortably.

Nationwide, occupany fell short of that by 3 percent in 1982, a result of slower growth of population than of beds, and the recession, which has discouraged some hospitalization. In Kansas, the occupancy rate was 70 percent.

At St. Joseph in Larned, occupancy was only 47 percent in 1982, leaving the hospital with a year-end operating loss of $55,748, out of a $2.2 million budget. The hospital also is trying to pay for a new $3.8 million addition.

HALSTEAD HOSPITAL made money in 1982 — more than $1 million — a year when fewer than two-thirds of its 180 beds were occupied, on average. The hospital tried to boost that rate last year by offering free room and board to patients who needed tests at the hospital, counting on return business and revenue from the tests.

"The drop-off in our census is why we got into that," said Administrator Richard Nierman. "We probably got $600,000 of new business because of it."

Like supermarkets, hospitals have long been able to juggle the prices of their products so their money-makers can carry the services that operate at a loss.

PATIENTS ARE regularly outraged over bills that show them they were charged $7.95 for a Valium tablet, as Link was.

But itemizing charges "doesn't have anything to do with what something costs," Wesley's O'Brien said. "It never made a damn bit of difference what the real costs were as long as the total bill added up: Did we get all our money back or not?"

The new repayment system will for the first time force hospital officials to keep close track of the actual cost of treating their patients, O'Brien and others predicted.

Even if the hospitals don't know the actual cost of single items for individual patients, they can tell where they make and lose money.

DRUGS, FOR example, usually are a big money-maker. Kansas hospitals mark up their drug charges 80 percent or 90 percent — or more. At St. Joseph in Wichita, the amount charged for drugs in 1982 was 121 percent over the hospital's cost, $4.7 million in extra cash.

At Pratt Regional Medical Center, which is managed by the Sisters of St. Joseph, the markup was 95 percent. That grossed the hospital about $482,000, more than twice the amount of the hospital's excess revenue in 1982.

Operating rooms run in the black as often as they run in the red. Anesthesiology, radiology and medical supplies often are money-makers, while emergency rooms and infant delivery services usually lose money.

EVEN IF a service loses money, hospital officials resist the prospect of dropping any of their four basic services — surgery, medicine, pediatrics and obstetrics — "because they've always felt they're really not a full-fledged hospital without the four basics," said Walter Wentz, chairman of health administration and education at Wichita State University.

The new payment system also will encourage hospitals to specialize in money-making fields even more than they have in the past.

"The idea is to develop programs that make you a little different, a little more attractive," Seubel, the market analyst, said. "You've got to capture more of a market share."

HE SAID hospitals have to expand in two ways at once.

"You have to expand by bringing the rest of the players in: the psychiatrists, the extended care, the outpatient services, the clinics. You can use outpatient services to funnel people into other patient services."

Seubel also said hospitals have to expand "horizontally, through integration with others." That already is occuring in Kansas, and administrators said they expect the pace to pick up.

In exchange for helping the small hospitals — at a price — the big magnet hospitals gain referrals from the small ones.

#2 - 3-2-84

SB 541 TESTIMONY

Presented by Ruth M. Lyon, Chairman of the AARP State Legislative Committee in behalf of the 194,000 AARP members in Kansas.

The time has come that something must be done to halt the run-a-way costs of hospital care. During the past ten years the U. S. Department of Labor places the rise at 450% and doctors' fees at 250%. This seems exhorbitant when compared to the rise in the cost of living at 150%.

Hospital costs continue to rise at 15% per year. In another six years at this rate the 450% will seem small compared to what we will be paying.

As a community college trustee, I am an employer whose medical insurance for individual employees in a Blue Cross and Blue Shield group plan has risen during the past 5 years from $40.48 to $107.07, a rise of 264%. We cannot continue to give a full membership as a fringe benefit at this rate. Other employers are finding themselves in the same boat.

The argument that Medicare's Diagnosis Related Groups program will control costs sufficiently is invalid, since that covers less than 50% of the billings. Neither will Blue Cross and Blue Shield's Competitive Allowance Program (CAP) for again only 50% of the people in Kansas will be protected. Are your children and grandchildren to be left unprotected?

We know that mandatory hospital cost regulation will work because experience is the best teacher. The six states operating hospital cost containment programs have significantly lower rates of cost escalation than the non-program or voluntary states. In 1981, the regulated states' costs increased 20% less than in the non-regulated states. If the non-regulated states had experienced the same average rate of increase, U.S. hospital costs would have been $12 billion less in 1981.

The hospital industry should never be mistaken for a classic free-market enterprise. Hospitals do not compete for patients, they compete for the affiliation of physicians. Only physicians can admit patients to hospitals and consumers are rarely offered an opportunity to exercise a choice over the hospital with which their doctor is affiliated.

State regulation would not add to hospital costs and thus be passed on to consumers. Hospitals already make reports to health insurance companies and to federal agencies. Under state regulation all non-federal hospitals and all purchasers of hospital care, current reporting requirements could be coordinated and the burden of regulation reduced.

Further, the benefits far outweigh costs. Connecticut, one of the first states to impose hospital cost regulation, estimates that its review responsibilities saved consumers more than $153.2 million in 1981.

Atch. 2

TESTIMONY on SB 541 by Ruth M. Lyon AARP

There is no well substantiated evidence that the quality of care in the cost containment states has suffered. The preference of many patients from outside the cost containment states--e.g., New Jersey, New York and Massachusetts--to receive care in these states indicates they do not perceive their care will be of lower quality. However, there will always be a dynamic tension between cost and quality of care. Therefore, it is critically important that quality assurance and control be maintained by strong Utilization Review (UR) and Professional Review Organization (PRO) procedures. In addition, new data collected under mandatory programs make it possible for hospitals and the state commission to assess quality in ways not possible until the mandatory program took effect.

Hospitals will not lose the affiliation of physicians because they don't obtain the most advanced and costly technologies that doctors demand for their practice. Although there will be doctors who are exceptions, we must assume that doctors will exercise the necessary professional self-discipline to contain costs. Wise physicians know that the continued escalation of health care costs must be contained to avoid a revolution in public opinion. State mandated programs provide physicians with opportunities to influence cost containment far more easily and more appropriately than federal programs. More important to this question is the fact that in the states with mandatory cost controls, there is no evidence that physicians have changed their affiliations or left the state because of state regulation.

Patients are not to blame for rising hospital costs. While everyone wants high quality health care, most patients, regardless of age, put off going to the hospital as long as possible and want to be discharged as soon as possible. The myth being perpetuated that older people get themselves admitted to hospitals because they're looking for rest or a vacation is particularly reprehensible. Physicians are the only persons authorized to admit anyone to a hospital and physicians who will admit a patient on a whim are not practicing professionally.

More cost sharing--such as increasing copayments and deductibles--would not result in greater savings than mandatory cost containment programs. As far as the elderly are concerned, increasing copayments and deductibles have proven to be neither an effective nor fair mechanism to reduce hospital costs. Since 1978, out-of-pocket payments for the elderly have increased by 95% with no consequent reduction in the rate of hospital cost increase. At the same time, physicians' fees not covered by Medicare increased by 19% over the last five years. What increasing copayments and deductibles has achieved is increasing the patients' burden while decreasing the governments'.

If a mandatory cost containment program is established, some hospitals will not be forced to close. Hospital closings are unrelated to mandatory cost containment programs, in and of themselves. Maryland, for example, has perhaps the most stringent cost control mechanism, yet has experienced a growth in hospital beds. While New York has witnessed the closing of some hospitals; loss of population rather than the existence of a hospital cost control program justified that outcome. New York has no cost control.

TESTIMONY on SB 541 Ruth M. Lyon

Hospital cost containment programs do not force hospitals into ruinous financial situations. Using Maryland as an example, that state's hospitals have had just the opposite experience. Based on the following measures, their situation is better now than it was before the mandatory program was implemented: (a) net income after taxes; (b) operating surpluses; (c) longterm debt-equity ratios; (d) operating margins; and, (e) reduced bad debts.

Under mandatory cost containment regulation, hospitals will not have a far more difficult time gaining favorable access to bond markets for financing. Let's look at Maryland again, both for an example of the facts and an example of the partnership between regulators and the industry that is possible. In Maryland, the Health Services Cost Review Commission provides the bond market with a guarantee that hospitals arranging for the issuance of bonds will receive sufficient revenues under tha state system to honor the bonds.

In closing I beg of you to consider the welfare of your constituents ahead of continued high profits for the medical care industry.

#3 ~~##~~- 3-2-84

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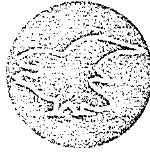
#4 - 3-2-84



AMERICAN ASSOCIATION OF RETIRED PERSONS

25 YEARS OF SERVICE

1983-1984
KANSAS STATE LEGISLATIVE COMMITTEE

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March 2, 1984

Chairperson Meyers and other members of the committee on Public Health and Welfare. I want to thank you for giving us the time to appear today to testify on Senate Bill 541. At the last meeting of the Sta te Legislative Committee of the American Association of Retired Persons the committee voted to accept the concept of this bill as the bill most in line with our priority in this field.

We represent the AARP on legislative matters in Kansas on the state level but we feel that this issue is one that affects all age levels and all strata of society. Our age level uses medical care more than any other because we are of the age that requires more medical attention. Also, we are anxious for something to be done soon. Our age group makes up over 11 per cent of the national population and over 13 per cent of the Kansas population and that per centage is growing. When you really think about it we are all consumers and we are all payers.

Granted there has been tremendous strides made in technology in the medical field, but there have also been great strides made in technology in many fields. Yet hospital costs have risen out of proportion to other costs. We realize that hospitals, either profit or non-profit need to make a profit to stay in business but we think it should be in line with other industries.

Medicare, whose patients account for about half of the hospital patients and Blue/Cross Blue/Shield in Kansas have gone on a Diagnostic Related Grouping Plan instead of the open end cost plus basis that has been in effect. This will undoubtably help some but this will not affect about half of the people that carry health insurance. Employers and employees alike have felt the pinch of high health insurance premiums caused by high costs of health care. States that have regulatory rate-setting commissions have experienced less of an increase in hospital costs than those that do not.

In a report by the President-Elect of the AARP last November she stated that "health care costs now consume more than 10 percent of our Gross National Product. America now spends nearly 1 billion per day on health care. These expenditures are expected to more than double by 1990.

AARP supports both regulatory and competitive market approach to health reform. For the short-term, we support a regulatory approach that includes cost controls at the federal and state levels for all payers and a cap on capital expenditures. Once we have reduced the rate of health care cost inflation to a tolerable level, we can then concentrate on the long-term task of restructuring our health care system into the more competitive, cost-effective system it can--and must--become".

We think that hospitals should charge all payers the same rates for the same service. That when only about half of the rates are under a fixed-rate system there is really not a handle on rates to be charged.

Our committee voted on the concept that there should be: 1, a commission with regulatory power--2, a uniform system of financial reporting--3, an advisory committee to give the commission advice on particular problems.

We think this bill has those characteristics and enough flexibility built in to meet special needs of individual hospitals.

We all want quality hea lth care at affordable prices.

Thank you again for giving us this time.

Morton F. Ewing

#8- 3-2-84

KANSAS HOSPITAL ASSOCIATION

TESTIMONY

on S.B. 541

Members of the Committee, the Kansas Hospital Association is pleased to have the opportunity to provide testimony on SB 541. The Association and its members are opposed to SB 541 and urge that it not be passed.

We are opposed to this "cost containment" initiative for several reasons. The following statements show the cost containment efforts already in place in the state.

Medicare

- The prospective payment system (PPS) in effect October 1, 1983 now limits reimbursement to fixed payment rates by DRGs. These rates, after a transitional period, will be purely federally set rates.
- According to a study done by KHA in late January, the effects of PPS on those hospitals that entered PPS on October 1, 1983 are (compares Oct.-Dec. '82 with Oct.-Dec. '83):
  1) a decrease in total days of 16.8%
  2) a decrease in Medicare days of 22.6%
  3) a decrease in total and Medicare discharges of 7.1%
- The implementation of PPS takes away the "cost-based" reimbursement incentive.

Medicaid

- Prospective payment for inpatient services began July 1, 1983 limiting reimbursement to a per diem based on 1981 costs rolled forward.
- A Primary Care Network (PCN) Program is being experimented with in three counties in Kansas which puts cost containment responsibilities on the managing physician.

Atch. 5

Blue Cross
- The (CAP) Competitive Allowance Program began January 1, 1984 and is "similar" to PPS. Reimbursement to the hospital is limited to the lesser of billed charges or the Maximum Allowable Payment (MAP) set by Blue Cross for a particular DRG.
- Blue Cross has implemented Health Maintenance Organizations (HMO, Inc.) in Topeka and Wichita and will be expanding to other communities.

All of these changes mean that 80 percent of the payments for hospitals in Kansas already are subject to some form of rate setting. The establishment of a commission, therefore, is redundant, and merely adds to the rate setting initiatives that are already taking place.

With respect to state rate review commissions, I would also like to point out to the Committee, the experience of our neighboring state, Colorado. In the late 1970s, a Colorado Hospital Commission was established. The legislation you have before you is very similar, if not identical, to the makeup of that Commission. The Colorado Commission was plagued with problems from the very beginning which resulted from a Commission staff that was unable to handle the complex job and excessive bureaucratic red tape created by the Commission. An example of this "red tape" was the uniform accounting system required by the Commission. These reports were generally 70 to 100 pages long and were extremely burdensome, especially to the small, rural hospitals with limited staffs and resources.

An interesting highlight is that one of the Senators who originally sponsored the bill, Senator Fred Anderson, ultimately introduced the legislation in 1979 to repeal the Commission. Thus, in just a year after its inception, the Colorado Commission was repealed.

In fiscal year 1979, the costs for operating the Colorado Hospital Commission were approximately $450,000. A similar effort today would incur a much larger cost, perhaps even triple or quadruple Colorado's $450,000 cost experience. Today it would not only be costly to hire the staff qualified to meet the requirements of a commission, but also to address the complexity necessary in a new DRG-based payment system. As the industry switches from traditional cost-based systems to systems dependent upon establishing prospective payment rates for 468 different diagnostic categories, it is obvious that we all will have to develop much more sophisticated systems for management, monitoring and reporting. Completely separate computer systems will need to be managed for the Medicare and Blue Cross groupers and the proposed State reporting system.

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

To summarize our opposition to SB 541, first of all, currently the major third-party payers account for 80 percent of the payments to Kansas hospitals. Each of these major payers has developed new prospective payment systems that will establish payment rates for Kansas hospitals. Secondly, an effort almost identical to SB 541 was attempted in Colorado, a state which is similar to Kansas in many demographic aspects. The Colorado Commission was a complete failure because it created an expensive, burdensome, bureaucratic nightmare. The final reason for our opposition is the high cost of establishing such a commission -- both to the State and the Kansas hospitals.

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

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

Why take a chance on state controlled cost containment when we already have in place systems that regulate 80 percent of Kansas hospitals' revenues and costs.

Again, thank you for the opportunity for allowing us to express to your our concerns on SB 541.

March 2, 1984

presented by Don Wilson —

#6- 3.2-84

KSNA
the voice of Nursing in Kansas

Statement of Kansas State Nurses' Association
by Executive Director Lynelle King, R.N., M.S.
Before the Senate Public Health and Welfare Committee

In Opposition to SB 541 - Hospital Cost Containment Act

Madam Chairperson and members of the Committee, my name is Lynelle King and I represent the Kansas State Nurses' Association, the professional organization for RNs in Kansas.

KSNA sincerely and strongly supports health care cost containment. A plank which has been in KSNA's Legislative Platform for several years states: "KSNA supports efforts to contain health care costs while insuring a high quality of patient care." In several previous hearings over the years KSNA has spoken in favor of measures which would cut costs and maintain or improve quality of health care.

Thus it is with regret that we must respectfully oppose SB 541.

Summary of our concerns regarding SB 541

- We ask that there be no further cost containment legislation until there has been ample time to observe the effects of prospective payment systems (DRGs) under Medicare and Blue Cross/Shield.
- Similar commissions in other states have had a negative impact on the amount and quality of nursing care to hospital patients and upon salaries of nurses, although nurse salaries are not a significant cause of high health care costs.
- The process a hospital would have to go through to gain a rate increase would be quite expensive - necessitating hiring economists, attorneys and others for this process, thus diverting funds away from the hospital's main mission - caring for patients.

If it is the wish of this committee to pass this bill favorably KSNA requests at least that a professional nurse be mandated for membership on the Advisory Committee. This might be accomplished by striking "~~or professional nursing~~" in line 0110 and adding after line 0114 (4) "One person representative of professional nursing in this state and who is knowledgeable in hospital administration".

Thank you for the opportunity to comment. We will be happy to answer questions.

Atch. 6

#9. 3-2-84

Everyone's Entitled to Blame for Soaring Health Costs

By Gregory E. Pence

I once was a liberal about financing medical care, then I became a conservative; now I am a nothing. I once thought physicians' fees caused increases in medical costs, then I blamed large institutions; now I blame everybody and nobody. I once thought escalating medical costs were a problem, later I thought they were a crisis; now I think our system may collapse before the second millennium.

I came to medicine as a new philosophy Ph.D. who had written a thesis about Rawls' liberal theory of justice. Starting in 1977, I began making rounds with physicians, seeing patients in oncology services, dialysis units and public clinics. Since then, I've talked with many physicians, learned much about what medicine can and cannot do, and come to believe that ominous patterns are emerging in American life and medical care.

Some people may doubt my belief that medical costs are uncontrollable. After all, Social Security was "saved" recently and surely we can do the same for medical costs. What the critics pointed out and what the Social Security Commission purposely overlooked was that three-fourths of Social Security's problems are in rising medical costs. The commission did nothing about this, and Social Security, as well as medical finance, is still in trouble.

Consider some alarming trends: Between 1968 and 1980, medical payments for veterans jumped 410% to $6.6 billion from $1.6 billion (after which two presidents vastly increased military personnel and their benefits). Furthermore, and for various reasons, between 1960 and 1980, recipients of Aid to Families With Dependent Children jumped to 11 million from three million, with these youngsters entering the world on Medicaid.

Physicians, too, must bear some blame. Very soon there will be too many physicians, and a glut of physicians creates not competition, but too much use of medical services. Moreover, just as veterans, AFDC recipients and middle-class patients feel entitled to their benefits, so physicians feel—after a decade of sacrifice and an average debt at graduation of $28,000—entitled to a salary often exceeding $100,000 a year.

Many other factors contribute to runaway medical costs, each bearing their own "entitlement": Private companies, managing hospitals and nursing homes or making pacemakers and dialysis equipment, feel entitled to a good profit (like the oldest for-profit medical business—pharmaceuticals). For every physician, there are seven allied health professionals, each wanting more pay and status—together bloating the national health-care bill. (There are even philosophers and ministers on the payroll at medical schools now!) Hospitals finance expansions through interest-bearing bonds, building inflation into future medical costs. More ominously, we may have a permanent class of unemployed and underemployed workers who do not qualify for Medicaid but lack private medical insurance. It is unlikely that we are just going to let these people die when they present themselves to emergency rooms late at night, and since the poor always have the worst health, the cost of their care will be high.

Lest we blame everyone but ourselves, notice, too, how we've become accustomed to seeing medical insurance as paying for most of our medical care instead of insuring us against catastrophic illness and accident. If our policies cover dentistry, eyeglasses, or even psychotherapy, we now feel entitled to these services.

The most ominous factor of all behind the coming crisis in medical finance concerns something of which I am a part: the baby-boom generation. Sometime in the next few decades, my friends and I will awake to find ourselves suffering from gall-bladder problems, kidney stones and heart murmurs, and will begin to knock hard at medicine's door. We will say, "We've paid for all these years; now we deserve something back!" At the same time, the marvelous advances of medicine (as well as its retreats, in maintaining indefinitely bodies whose biographies are over) will bequeath to us a large, medically expensive population made up of our parents. I feel frightened in realizing that the workers who will be obligated to pay for all the medical care for the by-then majority of senior citizens will be our children. The burden may be intolerable.

I've stressed the word "entitled" so far to buttress my conclusion: Medical costs are uncontrollable because we lack moral agreement about how to deny medical services. In fact, we've inherited incompatible, contradictory systems: in justice, a raw property-rights conservatism, for which high taxes are a kind of slavery, running up against Judeo-Christian egalitarianism, in which the effects of Fate's unequal health lottery must be minimized by a just society. Here claims for more personal income and lower taxes fight those of institutionalized charity. In ethics, we've inherited a sanctity-of-life principle from Hippocrates (a pagan who followed the mystic, Pythagoras), as well as the dominant quality-of-life principle of Socrates and most ancient Greek physicians. Combinations and permutations of these four beliefs can be interesting: low-taxation champions who favor government bans on abortion and forced, expensive treatment of defective babies; angry physicians complaining about government interference who murmur no protest when unions force businesses to pay for exorbitant medical policies or when governments "interfere" with workers to pay for medical care by increasing taxes.

Alas! Few of us are totally consistent in such emotionally charged areas. We want lower medical costs, but we want everyone to be treated.

Technology and medical advances have intensified, not solved, such moral dilemmas: A hemophiliac lacking a clotting factor does not die today, but his Autoplex units for three months cost $100,000; the usual method for feeding children who lack a digestive tract costs even more for a year of an infant's life but dooms the child to live in a hospital; the fantastically expensive neonatal intensive care units—which have saved thousands of "preemies" and other compromised babies who otherwise would have died—didn't exist 30 years ago. Even inside medicine there are dark rumblings about the new technologies, as seen in a family-practice physician's remark to me that "transplant surgeons will bankrupt the system" (followed by a diatribe on surgeons' fees).

Liberals want to subsidize medical care for the medically unfortunate and my compassion agrees with them: The healthy and wealthy should subsidize the sick and poor. Conservatives counter that this cannot go on forever: There are too many people, too many possible medical services, too many "entitled" and not enough "obligated." Again, I agree. Moreover, if the system does collapse, I can see that the poor and sick will be hurt the most.

But knowing the desperate need to cut costs, I also understand the physician's dilemma. I have been with him as he tries to tell a teen-age girl, in effect, that she's going to die because there's no money. Deciding how to say "no" to such people, and to say it with honesty and integrity, is perhaps the most profound, most difficult moral question our society will face in coming years. But face it we must, for the alternative is disastrous.

Mr. Pence is an associate professor in the philosophy department and the medical school at the University of Alabama in Birmingham.

Atch. 7

To: Senate Public Health and Welfare Committe

Date: March 1, 84

Re: Additional Statements in support of senate bill 806
Kansas Dental Hygienists

1. Concern was expressed about the possibility of overlooking pathological lesions or conditions under the proposed general supervision arrangement. Clarification:
    a. The dentist will still be responsible for diagnosis of each patient. as stated in the Bill 806.
    b. Only with the prior knowledge and authorization will dental hygiene procedures be performed.
    Therefore the dentist will be able to screen for medically compromised patients.

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2. Concern was expressed about the possible dangers of bacteremia from tooth cleaning. Clarification:
    a. A bacteremia can occur with simple toothbrushing!

3. Concern was expressed about the incidence of mortality resulting from local anesthetic injections alluded to on a recent 20/20 program.

Clarification:

1. Approximately six million cartridges of local anesthesia are administered weekly in the United States.
2. ~~One~~ studies of mortality rates from local anesthesia show an ~~extremely~~ low (approximately 1 in 45 million, T. Jastak) rates of death due to local anesthesia.
3. The 20/20 show dealt with combinations of medications, ~~none of~~ not local anesthesia alone. These combinations of medications are not in the purview of Senate Bill 806.

4. ~~Concern was expressed about~~

~~In closing, please refer to the enclosed survey,~~

Organized dentistry, KDA, is opposing these changes. However in a random survey of 25% of licensed Kansas dentists, 65% favored general supervision.

FREQUENTLY ASKED QUESTIONS ABOUT PROPOSED LEGISLATION

Why is KDHA seeking these changes?

- to provide greater access to quality oral health care to those Kansans currently without access.

Is it not to expand the potential job market?

- These changes may provide for an expanded job market, but our main concern is expanded accessibility since nearly 50% of the nations population will not be seen by a dentist this year.

Do the dental hygienists really want to have independent practice?

- No! The dental hygienists seek to offer preventive oral health care as a part of the dental team.

How do the dentists feel about these changes?

- The KDA is opposing these changes; however, in a one-on-one survey conducted by dental hygienists to dentists (random sampling of approximately 25% of licensed dentists) an average of 65% of those surveyed favored "general supervision" (84% of those dentists surveyed who employ a hygienist favored "general supervision); 69% of those dentists surveyed favored allowing the hygienists to administer local anesthesia under the direct supervision of the dentist (96% of those dentists surveyed who employ a hygienist favored this position); 65% of the dentists surveyed favored allowing the hygienist to administer nitrous oxide analgesia (91% of those dentists surveyed who employ a hygienist favored this provision); 72% of those dentists surveyed favored the opportunity for hygienists to offer regular preventive services (i.e. Prophylaxis, Oral hygiene instruction, Flouride treatments) to adult care facilities, institutions and school systems (99% of those dentists who employ a hygienist favored this provision).

How do other states stand with respect to these provisions?

- 12 states currently allow for the administration of local anesthesia by dental hygienists (some have special qualifications); 16 states currently allow for the administration of nitrous oxide analgesia (some with qualifications); 32 states allow for General Supervision as defined much the same way as we have defined it in the proposed legislation.

What will these changes do to the cost of oral health care?

- We cannot say that the cost of visiting the dentist will decrease but we do anticipate that the cost will increase much more slowly. Since these changes increase the prevention of dental disease, we can also foresee a long-range reduction in the overall cost of oral health care to citizens.

What educational requirements are placed on dental hygiene applicants?

- In order for a dental hygiene applicant to receive a license she must have a two or four year degree from an accredited dental hygiene program and pass State, Regional and National Board examinations. These exams are both written and clinical and cover such areas as oral inspections, radiographs, providing diagnostic aids, prophylaxis, applying topical agents, supportive treatment services, and emergency assistance.

Under these provisions, who would receive payment for dental services?

- The method of payment would not change.

What happens to liability under these provisions?

- Liability would remain much the same as it is now. Dentists, as well as hygienists, carry insurance. The dental hygienist in any practice setting is under the authority of either the dentist or an appropriate governing body under these proposed changes. Please remember that this bill is permissive; if the dentist feels unsure of his liability or of his hygienists' abilities, he does not have to authorize his hygienist to perform dental hygiene without his presence.

How are dental hygienists qualified to administer local anesthesia and nitrous oxide analgesia?

- Educational requirements in this area include head and neck anatomy, oral physiology, pharmacology, local anesthesia and pain control, chemistry, and microbiology. At the University of Missouri at Kansas City, for example, the dental hygiene student must take 750 hours of clinical time in order to receive their degree.

Senate Bill # 806 would allow for the administration of local anesthesia and/or Nitrous oxide analgesia by ~~qual~~ ~~dental~~ dental hygienists under the direct supervision of a dentist by dental hygienists who have been approved by the Kansas Dental Board to administer such agents.

A package of dental practice acts from other states ~~which~~ will be provided to the Kansas Dental Board to use as templates for the education/certification which is deemed necessary for a dental hygienists to administer Nitrous Oxide or local anesthesia. This may help with the drawing up of Rules & Regulations

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Dental Hygienists carry liability insurance ($39.00 per year for $1,000,000 coverage). The cost of dental hygiene or dental liability insurance is the same in states which allow general supervision and/or local anesthesia as in states which do not.

Both dental hygienists and dentists may be sued for lack of recognition on the part of the dental hygienist or lack of diagnosis on the part of the dentist of periodontal disease.

Jamie Menees, RDH

Senate Public Health and Welfare Committee

re: Support Testimony SB 806
March 1, 1984

In response to a question by Senator Hayden, I would like to clarify a statement in my testimony concerning root planing. To be most effective, the administration of local anesthesia and/or nitrous oxide-oxygen analgesia is ~~necessary~~ preferred, especially in initial root planing procedures.

preferred

Mary Jo Nigg, R.D.H.