Approved _____
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Rep. Sprague, Vice-Chairman at
~~Chairperson~~

3:30 ~~a.m.~~/p.m. on Tuesday, February 19, 1985 in room 521-S of the Capitol.

All members were present except:

Reps. Hoy, King and Turnquist - all excused

Committee staff present:

Emalene Correll, Legislative Research
Melinda Hansen, Legislative Research
Gordon Self, Revisor's Office
Helen Carlson, Secretary

Conferees appearing before the committee:

Mr. Werner A. Gliebe, Kansas Employer Coalition on Health, Inc.
Mr. Dick Brock, Kansas Insurance Department

The minutes of Thursday, February 14, 1985, were approved.

Ms. Hansen was asked to explain SB 19 and she said the bill had been amended in the Senate to allow insurance companies to negotiate and enter into contracts for alternative rates of payment with health care providers, and other parties, and to offer the benefits of those rates to insureds who select such providers.

Copies of the 1984 Interim study on Health Care Cost Issues were distributed to members, and Ms. Correll stated the Interim Committee was asked to consider 4 different points; (1) cost containment activities of other states; (2) extent competition is being introduced into the health care system; (3) review the effect of recent federal changes in reimbursement on Kansas hospitals; and (4) review health care cost containment initiatives in other states.

Mr. Gliebe said he had appeared before the Interim Committee and the Senate Financial Committee and does support the bill. He said many groups had input into the drafting of this bill and he sees it as a supporting element for Aetnas and other insurance groups.

Mr. Brock spoke in support of SB 19 saying the original purpose of the law was to make sure insurance companies transacted only insurance. This bill allows the insurance companies to participate in Preferred Provider Organizations.

Meeting adjourned at 3:50 PM.

Rex B Hoy

GUEST LIST

COMMITTEE: House Insurance DATE: 2-19-85

NAME	ADDRESS	COMPANY/ORGANIZATION
JACK ROBERTS	TOPEKA	BC-BS
Richard Harmon	Topeka	Humana, Inc.
Dick Brock	"	Ins Dept.
Werner Gliebe	"	KS. Employer Coalition on Health
HAROLD RIEHM	"	KS. ASSN OSTEOPATHIC MED
John Peterson		Ks Assn of Prof Psychologists
[illegible]	"	HAK

RE: Preferred Provider Organizations

NOTE ESPECIALLY

pages 87-90

1984 Interim Study

RE: PROPOSAL NO. 40 — HEALTH CARE COST ISSUES*

Proposal No. 40, as assigned to the Special Committee on Public Health and Welfare, directed the Committee to carry out a four-part study relating to health care costs. The Committee was asked to (1) review the certificate-of-need program to determine if it is an appropriate vehicle for ensuring that cost containment, accessibility, and quality of care are assured in the Kansas health care system; (2) determine the extent to which competition is being introduced into the health care system in the state; (3) review the effect of recent federal changes in reimbursement on Kansas hospitals, especially rural hospitals; and (4) review health care cost containment initiatives in other states and their applicability to Kansas.

Committee Study

The Special Committee on Public Health and Welfare considered one or more of the study topics assigned to the Committee under Proposal No. 40 at all but one of the interim meetings of the Committee. Because of the magnitude of the topics, a total of five days was spent on considering memoranda prepared by the staff, reviewing the cost containment activities of other states, reviewing health planning and certificate-of-need programs, becoming familiar with new methods of reimbursing health care providers and facilities, and hearing conferees.

Appearing before the Committee were: the Special Counselor to the Chancellor for Health Sciences and the Vice-Chancellor for Health Sciences from the University of Kansas Medical Center; representatives of Blue Cross-Blue Shield of Kansas, the Kansas Hospital Association, the Kansas Association of Osteopathic Medicine, the Kansas Medical Society, the

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* S.B. 17, S.B. 18, and S.B. 19 accompany this report.

Kansas Chiropractic Association, Kansans for the Improvement of Nursing Homes, the Statewide Health Coordinating Council, the Health Systems Agency of Northeast Kansas, the Health Systems Agency of Southeast Kansas, the Kansas State Nurses Association, the Kansas Employer Coalition on Health, the American Association of Retired Persons, the Kansas Association of Rehabilitation Facilities, Pyramid Life Insurance Company, Health Care Plus Health Maintenance Organization, Prime Health, Advocates for Disabled Access to Programs and Training, the Cedars, Northwest Regional Medical Center; the Secretaries of Health and Environment, Social and Rehabilitation Services, and Aging; staff from the Office of the Insurance Commissioner; and the Administrator of the Pratt Regional Medical Center. A number of the conferees appeared before the Committee on more than one occasion in order to speak to different aspects of Proposal No. 40.

Certificate of Need

State Actions. Established in 1974 as part of the federal Health Planning and Resource Development Act, certificate-of-need regulation is designed to provide a review, by an outside review agency, of capital expenditures proposed to be made by or on behalf of a health facility. In general, the individual states specify the facilities that are subject to review and establish a threshold amount of expenditure that brings the proposed capital expenditure under the review procedure.

In 1984, almost every state legislature that was in session considered at least one piece of legislation that pertained to health planning or certificate of need. The Kansas Legislature was no exception, considering and enacting bills that concerned the extension of the Kansas Health Planning and Development Act and amendments to the statutes that govern the certificate-of-need procedure established pursuant to K.S.A. 65-4801 et seq.

In 1984, 45 states had certificate-of-need programs in place. Four states — Arizona, Idaho, Minnesota, and New

Mexico — had allowed their laws to lapse, and one state — Louisiana — has never enacted certificate-of-need statutes, although serious consideration was given to doing so during the 1984 Louisiana Session. The Utah certificate-of-need program is scheduled to expire on December 31, 1984, and the laws of Indiana, Kansas, and Texas are currently scheduled to lapse in 1985.

Certificate-of-need regulation varies greatly from state to state, reflecting, perhaps, the different market forces in the states, the differing perceptions of the role of certificate of need, and progam performance. In some states the types of facilities subject to certificate-of-need review are very limited, i.e., the law applies only to hospitals and nursing homes. In others, certificate-of-need requirements cover a number of different types of facilities and providers. For example, 37 states require a certificate of need for home health agencies, although many apply the certificate-of-need review only to institutional-based home health agencies. Eight states have extended the certificate-of-need review process to equipment purchases made by a physician's office regardless of whether such equipment is for inpatient use. In six states the review procedure covers all equipment purchases by a physician's office, one requires a certificate of need only for imaging equipment costing over $400,000, and one state requires a certificate of need for the purchase of any major medical equipment for a physician's office if the capital expenditure exceeds $400,000. In 18 states, a certificate of need is required for equipment purchased by a physician's office if the equipment is to be used for services to hospital inpatients.

A new development in certificate-of-need programs is the placing of moratoriums on one or more types of certificates of need. Ten states have a moratorium of one type or another in place for fiscal year 1985. Facilities or services subject to the moratorium cannot expand services or offer new services during the moratorium. Five states have a moratorium on the approval of certificates of need for nursing home beds, one moratorium applies to major medical equipment, one applies to home health, one to alcohol facilities, one is a three-year moratorium on hospital beds, hospitals and hospital

relocation, and one applies to all certificate-of-need applications except those of an emergency nature or for the replacement of necessary, existing equipment.

Another new development in certificate of need is the imposition of statewide caps on the total annual value of certificate-of-need approvals for fiscal year 1985. Three states have imposed actual dollar limits and one has imposed a statewide limit on the number of nursing home beds governed by certificate of need. Other states were considering capital caps during 1984.

Federal Actions. During 1984, two bills were pending in the Congress that would have reauthorized the national health planning program. One would have extended the program for three years, with a $64 million annual appropriation authorization, and would have increased the minimum state thresholds for certificate-of-need review to $1 million for capital expenditures and to $500,000 for major medical equipment and new institutional health services. The second bill would have provided block grants to the states for health planning, with an annual appropriation authorization of $25 million. Under this latter approach, the states would have been required to operate certificate-of-need programs in order to be eligible for federal funds. Neither bill was enacted by the Congress, and health planning was continued through the enactment of a continuing resolution through federal fiscal year 1985.

The Department of Health and Human Services has adjusted the federal minimum expenditure thresholds applicable to certificate-of-need programs that comply with federal law. The new thresholds are $714,000 for capital expenditures and $297,500 in increased annual operating expenditures or changed institutional services. The minimum thresholds were $600,000 and $250,000, respectively, previous to the 1984 adjustment. The threshold for major medical equipment remains at $400,000.

Alternatives. Several alternatives to the current certificate-of-need laws were suggested to the Committee by conferees. Several conferees recommended that the thresholds for capital expenditures and new health facility services be increased. Two options were discussed, i.e., to increase the thresholds to those that comply with federal law or to increase the capital expenditure threshold to $1 million, placing the Kansas threshold out of compliance with federal minimums. It was noted that no sanctions are being imposed on those states whose current thresholds exceed the federal minimums.

A second option discussed by conferees and the Committee is to allow the certificate-of-need law to sunset and to enter into a federal 1122 agreement with the Department of Health and Human Services. Section 1122 of the Social Security Act requires that capital expenditures over $600,000 be approved under a state review in order to be eligible for reimbursement for interest and depreciation under Medicare and Medicaid reimbursement and by maternal and child health programs. Nineteen states now participate in the 1122 program.

A third alternative which was suggested by a number of conferees is to establish a two-year moratorium on the construction of new health facilities or additional facility beds. There are several examples that could be considered if this alternative were chosen.

Several conferees suggested that certificate-of-need review be extended to cover all or some additional providers. The purchase of major medical equipment for physicians' offices was the most common extension recommended. Alternatively, it was suggested that some providers could be exempted from certificate-of-need reviews where market forces appear to offer sufficient control on the expansion of facilities.

It was also suggested to the Committee that a ceiling or cap be placed on the applications that may be approved under certificate of need in any one year. A dollar cap could be established by the Legislature or by the review agency pursuant to legislatively established guidelines.

Conclusions and Recommendations. In part, because of the Committee study of other issues included under Proposal No. 40, the members conclude that it is not desirable to sunset

the Kansas certificate-of-need program on July 1, 1985. As will be noted in other sections of this report, new reimbursement systems for hospitals are not yet fully in place and it is too early to judge the effect of changes in the way such facilities are reimbursed by Medicare and Blue Cross-Blue Shield. Whether or not market forces will prove to be a sufficient constraint on capital expenditures and will control unnecessary and costly expansion of health facilities cannot yet be determined. Further, not all health facilities regulated under certificate of need are as yet subject to forces that act to restrain unnecessary expansion.

As noted in another section of this report, the entire health care industry is in a state of transition, with the outcome as yet unclear. In the next several years a number of pressures will be exerted on health facilities, some of which may lead to responses involving large capital expenditures for renovation or change while capital costs can still be passed through to Medicare and other third party payors. In addition, some facilities may close and others may change the nature of the services they provide. During the transition years, it is important that a review procedure remain in place that can consider access to health care as a part of the review process.

For the above reasons, the Special Committee on Public Health and Welfare recommends that the Kansas certificate-of-need program be extended until July 1, 1987. At that time, the Legislature can again review the desirability of continuing certificate-of-need reviews in the light of changes in the health care industry. S.B. 18 implements the Committee recommendation.

The members of the Special Committee on Public Health and Welfare considered other changes in the Kansas certificate-of-need laws, including a restoration of the review of any decrease in health facility beds and services deleted from the law by the 1984 Legislature and expansion of the certificate-of-need thresholds for capital expenditures and new health facility services. The Committee concludes that review of any decrease in health facility beds or services should not be restored to the certificate-of-need program and, further concludes that the thresholds triggering review of capital expenditures and new health facility services should be increased to the new federal minimums.

The Special Committee on Public Health and Welfare recommends that the capital expenditure threshold be increased to $714,000 and the threshold affecting new health facility services be increased to $297,500. No change in the threshold for major medical equipment is recommended. S.B. 18 amends K.S.A. 1984 Supp. 65-4805 to implement this recommendation.

Competition

There is little need to review the rates of increase in health care costs in the last two decades since interim committee reports dating as far back as 1973 have chronicled the annual rise in health care costs at a rate greatly in excess of the annual rise in all other sectors of the economy. In 1965, health care expenditures of $50 billion represented 6.1 percent of the gross national product in the United States. Eleven years later health care expenditures of $150 billion represented 8.7 percent of the gross national product. By 1983, health care expenditures in the United States were over $350 billion and accounted for 10.8 percent of the nation's gross national product. According to the Department of Health and Human Services, health care costs in 1983 totaled $1,459 per person, up from $1,337 per capita cost in 1983. Although 1983 health care expenditures increased 10.3 percent over 1982 expenditures, the annual increase was the lowest in the past ten years.

A change that has come about as health care costs have risen at alarming rates over the last decade is the perception on the part of consumers, employers, unions, providers, government, and third party payors of the health care system in the United States. This fact is illustrated by the results of a poll conducted for "Business Week" by Louis Harris and Associates in September of 1984. Almost half of the 1,999 individuals surveyed by the Harris poll said that, although there are "some good things" about health care in the United States, "fundamental changes are needed to make it work

better." A majority of those polled believe that the prices charged by doctors and hospitals and the cost of drugs and laboratory tests are "unreasonable." Hospital charges were considered to be either "somewhat" or "very unreasonable" by 70 percent of the Harris sample.

Another sign of the change in attitudes about health care that has come about in recent years is the fact that the Harris poll revealed that 69 percent of the persons surveyed would find it acceptable to join a health maintenance organization, 60 percent would find government price controls on doctors and hospitals acceptable, 50 percent would find it acceptable to increase patient deductibles, and 70 percent believe that an expansion of a system of uniform, pre-set fees based on a specific treatment such as the system instituted for Medicare hospital reimbursement would be acceptable. Not surprisingly, only 37 percent of those polled by the Harris organization believe that making the patient pay a higher percent of the cost of treatment is desirable, but 58 percent said they would be willing to use only those providers on a list provided by their insurer if they were assured of paying a smaller share of the cost of health care treatment.

Kansas has not been immune to the threat of escalating health care costs and changes in attitudes toward health care. According to a survey conducted by the Kansas Employer Coalition on Health Care, Inc., 77 percent of the 335 employers who responded to the survey said health costs are a "major" concern. The costs of the state-operated Medicaid Program, driven by ever-increasing health care costs, have lead to imposition of an increasing number of cost containment measures, including co-payments, a reduction in covered services, and caps on provider reimbursement. Rate increases in health insurance and Blue Cross and Blue Shield have led third-party payors to seek new ways to control the cost of health care provided to their insureds in order to remain competitive. Health maintenance organizations operating in Kansas have increased to eight, up from two operating in the state a few years ago. Preferred provider organizations, i.e., an arrangement between a provider or providers and an insurer, group, or employer who guarantees a patient case load to the provider in return for a specified discount rate for the

service, are being formed, both by private providers and by institutional providers.

Two other long-standing attitudes or beliefs are being questioned as interest in restraining increases in the cost of health care becomes more widespread.

Some health economists are questioning the belief that health care is immune to the competitive market forces that affect other segments of the economy. Some economists believe that if competition in health care is encouraged, it will lead to more efficient and effective providers because rewards in the health care system will be changed by the introduction of market forces. Competition will not reward those providers who provide more care than is efficient and effective as consumers become more aware of costs and have more choice of providers and as reimbursement systems are developed that are not cost-based.

A second belief that is under fire is the idea that the only way to control cost and guarantee quality health care is through extensive regulation and governmental mandate. While no one is yet suggesting that all regulatory activities should be abolished, new regulatory initiatives are being scrutinized more carefully by legislative bodies and administrators. Mandated health insurance benefits are an example of one area in which legislatures are taking a more careful look at governmental intervention as evidenced by the much reduced enactment of mandated coverages in the last year. Perhaps legislators are developing an awareness that state statutes requiring all health insurers to cover specified benefits reduce the consumer's ability to choose those benefits that best fit his needs and may affect negatively efforts to control increases in health care costs.

In short, attitudes and beliefs about the health care system in the United States are undergoing change. It appears that on a continuum represented by intensive regulation at one end and free, unrestrained competition at the other, there is a movement nationwide along the continuum toward competition.

Conclusions and Recommendations. The Special Committee on Public Health and Welfare believes there is evidence that to some extent, and some believe to a large extent, Kansas is moving toward a competitive model in health care and away from a strictly regimented model of health care. In support of this belief, the Committee notes the growth of health maintenance organizations in Kansas, the development of preferred provider organizations, the initiation of new models of out-patient care, changes in the way providers are reimbursed that have been initiated by Blue Cross-Blue Shield, shortened lengths of stay in Kansas hospitals, the development of a statewide employer coalition on health, increased employee involvement in health care cost control through increased cost sharing, and increased advertising by providers.

The Committee does not believe that Kansas is moving as rapidly toward increased competition in the health care system as, for example, Iowa where strong employer coalition pressures, local initiatives, and a consciously adopted public policy favoring competition appear to have created a climate favorable to fostering the growth of competition.

The Committee recommends that the Kansas Legislature be more aware of the potential for fostering or inhibiting the growth of competition as it considers legislation proposed by provider groups, health insurance legislation, interest group legislation, regulatory initiatives, and appropriations.

The Committee did find, as a result of its consideration of competition in the health care field, that a Kansas statute, K.S.A. 40-231, has been construed to prevent insurance companies from contracting or entering into agreements with preferred provider organizations or other providers to furnish care at an agreed-to rate for the company's insureds. The Committee concludes that the statute should be amended to exempt contracts or agreements entered into between an insurance company and a provider of health care to provide care for the company's insureds.

The Committee has prepared a bill that amends K.S.A. 40-231 and recommends that the 1985 Legislature enact S.B. 19.

Reimbursement Systems

Fee For Service. The traditional fee for service or cost-based system of reimbursing providers of health care for their services has been blamed for creating incentives to provide more care than is necessary in all cases since the provider is reimbursed for whatever level of care is given. In addition, there is no incentive in a cost-based reimbursement system for providers to become more efficient because they are reimbursed for their costs regardless of how such costs may be measured against other providers of the same service. The disincentive appears to become particularly significant in the case of health care facilities when all decisions in regard to capital investment are reimbursed regardless of whether or not they are wise decisions in terms of market conditions.

Cost-based reimbursement is now seen as one of the causes of the oversupply of hospital beds that now appears to exist in Kansas and in the nation, as the evil behind excessive lengths of stay in hospitals and excessive hospital admissions, and in the oversupply of physicians that now is being produced in the medical education system. Cost-based reimbursement, which in the case of individual providers is still the norm, is thought to have become a more significant factor in rising health care costs as payment for services increasingly shifted from the individual patient to third party payors and as medical technology became increasingly expensive. Because advances in medical technology were reimbursed in the traditional cost-based system they were often introduced without adequate study of their cost effectiveness.

Prospective Reimbursement. As health care costs rose dramatically after 1965, studies of the health care system in the United States led some observers to believe that the only way to stem cost inceases was to change the way in which health care providers were reimbursed for their services. Thus, a movement toward prospectively set rates for hospital services began. Under a prospective reimbursement system, the provider knows the amount that will be received or the approved rate in advance of providing service. Initially, prospective rate setting, as it applied to hospitals, involved a review of the hospital's actual costs in the previous year,

either by service or by daily rates. Following the review of costs and rates for the previous year by a Commission or other outside entity, the hospital's rates for the next year were set (pproved in advance. Although the actual process is much m.re complicated than the brief summary noted above, this type of prospective rate setting has been in place in Maryland, Washington, and New York for a number of years. By 1984, 11 states had a mandatory rate setting system in place for hospitals. The systems and methodology vary somewhat among the 11 states as does the coverage of the rate review systems that are in place. Five of the 11 states cover all payors under their mandatory rate setting systems, i.e., Medicaid, Medicare, Blue Cross, private payors, and insurers. One state, Connecticut, is scheduled to cover all payors in 1986. The inclusion of Medicare and Medicaid under rate setting systems requires a federal waiver.

While hospital rate review and prospective rate setting appears to have constrained increases in hospital costs in some of the states in which the system is applied, this type of system does not necessarily control length of stay or unnecessary hospital admissions, although some of the review agencies do look at such factors.

Diagnosis Related Groups. A new form of prospective rate setting for hospitals appeared on the scene when New Jersey began utilizing a type of prospective rate setting often referred to as a diagnosis related group (DRG) system. Under th rospective payment system utilized in New Jersey, a fixed rate of reimbursement is set for a hospital case in advance of the provision of service by the hospital.

In order to set prospective rates for individual cases, it is necessary to classify diseases and injuries into groups by diagnosis. The original diagnosis related groups were developed at Yale University in the 1970s and utilized the cause of the disorder to be treated and the organ system involved for classification purposes. The original classifications included 383 DRGs. In 1982 the DRGs were revised and expanded to 467. Other changes were also made in the classification system through the refinement of disease classifications, the inclusion of chief surgical procedures involved, and the addition of factors relating to comorbidity, complications, age, and death. It is the 1982 classification system that is used as the basis for prospective rate setting in New Jersey and by Medicare, although Medicare utilizes only 356 DRGs that are appropriate to the Medicare population.

Medicare. In 1981, the federal Omnibus Budget Reconciliation Act authorized the states to develop alternate hospital reimbursement systems within certain federal guidelines. The 1981 legislation was followed in 1982 by the Tax Equity and Fiscal Responsibility Act which set a limit on Medicare expenditures at a maximum of $35 billion in federal fiscal year 1984 and required the Secretary of Health and Human Services to develop a legislative proposal for the reimbursement of inpatient hospital services under Medicare on a prospective rate basis. The legislation prepared by Health and Human Services was submitted to the Congress in December of 1982 and became law on April 20, 1983.

The federal legislation adopted in 1983 provides for reimbursement for the hospital care of Medicare patients on the basis of DRGs. The new reimbursement system also involves the collection of case mix data for each hospital and the development from such data of a case mix index which attempts to reflect the relative cost of each hospital's mix of Medicare patients compared to the national average mix of Medicare patients.

The Medicare DRG case mix system is now being used to determine a part of the reimbursement to individual hospitals for Medicare patients. (For a more detailed summary of the Medicare DRG system see a memorandum prepared for the Special Committee on Public Health and Welfare dated June 26, 1984.) The new system began with each hospital's new cost reporting period following October 1, 1983, and has a three-year phase-in period. The phase-in allows each hospital to be reimbursed partially on its own cost base and partially according to DRGs. The cost-based portion of the reimbursement is, however, limited as to the amount of increase by federal law. Presently, the DRG portion of the reimbursement reflects regional differences, but the regional differences are to be reduced each year until the end of the phase-in period and then eliminated. During the three-year phase-in of the DRG

prospective reimbursement system for Medicare, payments are to be made as follows:

1st year — 25 percent based on specific DRG rates and 75 percent hospital specific rates;

2nd year — 50 percent based on a combination of national and regional DRG rates and 50 percent hospital specific rates;

3rd year — 75 percent based on a combination of national and regional rates with a heavier weighting of national rates and 25 percent hospital specific rates; and

4th year — 100 percent national DRG payment rate, either urban or rural.

During the phase-in, both the DRG rate and hospital specific rate are set prospectively. Some few hospitals or units of hospitals are exempted from the DRG system, and special rate adjustments can be made for certain other hospitals. Outliers (those cases that cannot be placed in a DRG category) are subject to additional payments, and three hospital cost items are currently not included under the prospective payment system for Medicare, but are still being reimbursed on a cost basis until Congress acts to include them under prospective payment. The items that are still cost-based for reimbursement purposes are big items for some Kansas hospitals, i.e., capital costs, including depreciation, interest, and rent; return on equity; and education costs. These costs are also to be phased in under a schedule set out in the federal law.

For a number of reasons it is too early to make a judgment about the effect of the new prospective reimbursement system being utilized by Medicare on Kansas hospitals. For one, a number of Kansas hospitals have been operating under the system for only a brief period of time because their new fiscal year did not begin until July 1, 1984. For another, the new system has only a limited effect at this time because it is being phased in over a period of time. A third reason that any judgment is premature is the fact that a part of the hospital's costs is still being reimbursed on a cost-related basis. At this time, it is not known how capital may be treated in the future and this could be a significant issue for some Kansas hospitals. Still a fourth factor is the initiation on January 1, 1984, of a prospective reimbursement system based on DRGs by Blue Cross of Kansas. Although somewhat different from the Medicare system, the Blue Cross system has impacted Kansas hospitals significantly.

While it is too early to make an informed judgment about the impact of DRGs, the Kansas Hospital Association reported to the Committee at its October meeting that hospital utilization has been lowered and the financial position of some rural hospitals is threatened. The Hospital Association's survey of hospitals in the First Congressional District indicated that some rural hospitals could close due to insufficient patient load, lack of community support, lack of cooperation from the medical community, Medicare funding, or changes in the volume of other services provided by the hospitals. The Medicare wage index for rural hospitals was also singled out by the Association as a problem that is being worked on with federal officials. Final results of the Hospital Association study are to be released early in 1985.

The Committee also heard from representatives of two hospitals that their financial position remains strong at this time. It was suggested by one hospital administrator that reduced admissions and lower lengths-of-stay do not reflect a reduced quality of care, but reflect unnecessary admissions and length-of-stay in the past. The Committee also notes that hospital bond issues on the ballot in several communities this year passed, usually by strong majorities. Thus, it appears that community support for rural hospitals remains strong.

Conclusions and Recommendations. The Special Committee on Public Health and Welfare concludes that any judgment of the effect of Medicare reimbursement changes on Kansas hospitals is premature. Any such judgment in the future will also need to take into account changes in reimbursement put into place by other payors such as Blue Cross, Medicaid, and other third party payors.

While the Committee believes it is too early to speak to the future of Kansas hospitals as far as reimbursement changes are concerned, the members note that health care is now in a transitional period with changes other than those re ng to reimbursement taking place. Changes in ownership, the degree to which communities continue to support small hospitals, the degree to which hospitals are able to adapt to change, and other factors will affect the future of these institutions. It appears inevitable that some Kansas hospitals will close and that others will restructure the services they provide, particularly moving away from acute care to emergency care or increased emphasis on long-term care.

The possibility that some rural hospitals may close in the future raises serious questions about geographic access to care for rural residents of Kansas. Additionally, new reimbursement systems that do not include payment for uncompensated care raise serious questions about financial access to care for some Kansas citizens. The latter problem is intensified by the increasing number of persons who have been priced out of the health insurance market as noted in a later section of this report.

Because the Committee is concerned that the health care needs of rural Kansans may be endangered as the health care system changes over the next few years, the members recommend that the Statewide Health Coordinating Council be directed to study the role of rural hospitals in providing access to c e for rural Kansans in the future and the relationship of uc ole to health planning, with a report of the Council's findings and recommendations to be made to the Governor and the Legislature on or before December 31, 1985. The Committee does not intend that this recommendation be construed as a recommendation that each and every hospital in the state is to be kept open, but rather that effo e made to insure that a strong planning process is in place to give direction to efforts to insure access to health care for rural citizens of Kansas.

S.B. 17 implements the Special Committee's recommendation.

Cost Containment Activities of Other States

The Special Committee on Public Health and Welfare reviewed a number of activities that are taking place in other states in an effort to control increases in health care costs. In some instances cost containment measures originate with the private sector as in Arizona and Iowa. In many other instances, cost containment efforts are initiated by state government because of the increasing burden of Medicaid on state budgets. Numerous examples of the latter were presented to the Committee. Those efforts being made in Arizona and California to contract for indigent care on a prospective basis, the effort to encourage competition in the delivery of health care being made in Iowa, the comprehensive package of legislation enacted in Wisconsin in 1983, the implementation of DRG reimbursement for Medicaid in some states, and efforts to control long-term care expenditures through the development of services provided at the community level as an alternative to institutional care being made in most states, all rank as innovative and worthy of additional consideration in Kansas. The initiatives taking place in other states are described in some detail in various staff summaries and reports made available to the Committee.

Medicaid. In general, states have revised their Medicaid programs to control the cost increases in such programs. Although there are a variety of approaches, 14 states now reimburse physicians or hospitals that care for Medicaid patients on a capitation basis; 26 states collect copayments or deductibles or both for selected services; 17 states froze physician fee schedules in 1983; 23 states have some Medicaid recipients enrolled in health maintenance organizations; 4 states froze hospital reimbursement rates in 1983; 6 states reimburse hospitals on the basis of DRGs; 12 state Medicaid programs base hospital reimbursement, in part, on occupancy rates; 21 Medicaid programs do not reimburse for inpatient surgery if the surgery could be done on an outpatient basis; 12 states require second surgical opinions; 15 states require some type of prior authorization for hospital care; 21 states limit the number of hospital inpatient days for Medicaid recipients in some way; 2 states require family contributions for Medicaid recipients in nursing homes; 35 states participate in the

ome and community-based care waiver program; and 44 ta' require preadmission screening for nursing home admis-ior.

It should be noted that Kansas has adopted a number of he above noted Medicaid initiatives. Others have yet to be ully explored by the Kansas Medicaid Program.

Other Medicaid cost containment initiatives include hanges in nursing home reimbursement, provider restriction, ontracts with providers, and the purchase of selected durable oods in bulk lots. Three state Medicaid programs require ompetitive bids for laboratory services.

Thirty-two states operate federal-state medically needy rograms, and one state, Florida, has scheduled participation n the federal-state medically needy program for those cate-orically related to Aid to Families with Dependent Children AFDC) and Supplemental Security Income (SSI) beginning in 986. In 21 states, state or locally funded and operated rograms for the medically needy who are not related to ederal programs were in place in 1984, although these pro-rams tend to vary in scope and coverage.

Hospital Cost Containment. Eleven states had a pro-pective hospital rate review program in operation in 1984 hat ther established hospital reimbursement limits or re-iew and approved hospital budgets. Five of these rate eview programs include all payors.

In 24 states, laws or regulations were in place that equire hospitals to report selected data to the state in a rescribed form and on a prescribed basis. Seventeen states ad a law or regulation that requires hospitals to release nformation to the public on procedures and charges.

Adult Care Homes. In 1984, three states require nursing omes to provide a minimum amount of care to the medically ndigent as a condition of licensure or relicensure, and three tates require insurance carriers to include in their policies overage for selected costs of nursing home care provided to n insured.

Insurance. In 1984, eight states had enacted laws specifically allowing the creation and operation of preferred provider organizations. Four states have designated the state insurance commissioner as an overseer of the formation and administration of preferred provider organizations. Four states have enacted laws that prohibit discounts by providers to third party payors unless the discounts can be justified by provider cost savings.

State mandated insurance coverage for health related conditions is summarized in the Report of the Special Committee on Commercial and Financial Institutions on Proposal No. 7.

Twenty-two states now mandate a health insurance continuation privilege for workers in a group who are laid off or terminated from employment. Thirty-two states mandate conversion privileges for group members who are laid off or terminated from their employment.

Six states have created risk pools for high risk individuals or those who are uninsurable under conventional underwriting standards, and eight states have laws that provide for a state insurance program available to individuals who experience catastrophic health care expenditures. However, two of the states with laws providing for "catastrophic" state insurance are not operating programs, and one state's law will become effective in 1985 only if 50 counties agree to participate.

In one state, employers of over 25 employees must offer a preferred provider organization option if one is available in the area, and in ten states, employers are required to offer employees the choice of a health maintenance organization or insurance if a health maintenance organization is available. These state mandates are in addition to the federal requirements that affect some employers.

A number of states have made changes in their state employees' health insurance programs in the last several years.

Problems Associated with Cost Containment Efforts. Two problems are emerging as the states and third-party

payors emphasize cost containment efforts in the health care field.

The first is an increase in the number of persons who are choosing not to purchase health insurance because the cost of such coverage is too high. A survey conducted by the Robert Wood Johnson Foundation in 1984, indicates that about 7 percent of the population does not have health insurance coverage and is not eligible for government medical assistance. The survey indicates that the number of persons "going bare" is increasing.

A second problem, emerging as hospital cost containment efforts and other cost containment measures are put in place by third party payors, is that cost shifting will be reduced, i.e., the ability of providers to shift the cost of care for the medically indigent to other payors is diminished.

Both of the problems that are highlighted above suggest that states may be faced with a substantial number of persons whose health care expenses may become a state and local government responsibility, in whole or in part. Several states, among them, Florida and Oklahoma, have enacted legislation within the past year to attempt to deal with this problem.

The potential magnitude of the problem is illustrated by a dilemma that New Jersey faces. New Jersey has been told by the federal government that the state's waiver to cover all pa s under the state's hospital prospective rate system will not be renewed unless the state can keep Medicare costs at or below the national Medicare average. Presently, the New Jersey DRG system includes reimbursement for bad debts and all indigent care incurred by New Jersey hospitals; whereas Medicare recognizes only those bad debts and indigent care costs attributed to Medicare patients. In 1984, New Jersey expects that hospitals will be reimbursed for approximately $200 million in bad debts and indigent costs. Medicaid and Medicare constitute about half of all hospital costs in New Jersey, so the loss of the federal waiver would mean that more than $100 million in reimbursement would be lost to hospitals in the state. The options being explored are increasing the rates paid by other payors, state assumption of the federal revenues lost, or state or local assumption of the total costs of bad debts and indigent care.

Conclusions and Recommendation. The Special Committee on Public Health and Welfare notes that much information is available from other states on cost containment efforts. In this sense, the states appear to be serving as laboratories for testing cost containment approaches. Therefore, continued communication among state legislators through the National Conference of State Legislatures should be stressed in order that each state may benefit from the experience of others.

The Committee has concluded that the approach that Iowa is taking to health care costs may have merit for Kansas. Iowa has adopted, as a state policy, the encouragement of competition in health care. This policy is the result of the recommendation of a commission that was created to outline a statewide strategy to control health cost escalation. The commission concluded that market forces and incentives were the best approach for Iowa. However, the Special Committee notes there are forces at work in Iowa that do not, as yet, appear to be equally as well developed in Kansas, i.e., private sector initiatives in redesigning health benefits and in developing utilization review contracts, private sector development of alternative delivery systems, the development of local health care coalitions in urban areas, and a concerted effort that began in the early 1980s by business, unions, consumers, insurers, and the health care industry to control costs. A good working relationship between health care coalitions and the Iowa Legislature appears to have developed also.

Respectfully submitted,

November 29, 1984

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Special Committee on Public
Health and Welfare

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Sen. Paul Burke
Sen. James Francisco
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Sen. Bill Morris*
Sen. Eric Yost*

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Rep. Thomas Walker

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* Senator Eric Yost served on the Committee beginning with the October meeting when he replaced Senator Bill Morris.