Approved ADP 3-16-90
Date

MINUTES OF THE HOUSE COMMITTEE ON LABOR & INDUSTRY.

The meeting was called to order by Representative Arthur Douville at
Chairperson

9:08 a.m./~~p.m.~~ XXX on February 28, 1990 in room 526-S of the Capitol.

All members were present except:

Representative Dorothy Flottman - Excused

Committee staff present:
Jerry Donaldson - Legislative Research Department
Jim Wilson - Revisor of Statutes' Office
Cindy Wulfkuhle - Committee Secretary

Conferees appearing before the committee:
Dick Thomas - Division of Workers Compensation
Jim Schwartz - Kansas Employee Coalition on Health

The meeting was called to order at 9:08 a.m. by Chairman Douville. The minutes of February 21, 22, 23 and 26, 1990 were distributed and unless objections are presented by Tuesday, March 6, 1990 at 9:00 a.m. they will stand approved as presented.

Chairman Douville proposed to send HB 3069 over to Appropriations Committee and then have it referred back to us, so we can study it some more.

HB 3028: Relating to medical, physical and vocational rehabilitation

Dick Thomas, Division of Workers Compensation, appeared before the committee as a proponent to the bill, Attachments #1, 2 & 3. He proposed that on page 8, line 7 we put in a subsection (n) for the definition of the word "assessment".

Representative Schauf made a motion to add subsection (n) - the definition of "assessment". Representative O'Neal seconded the motion. The motion carried.

Representative Schauf made motions to change the word "decision" to "recommendation" in line 7 of subsection (n), and on line 2 include the words "the need for" after the word "determining". Representative O'Neal seconded the motion. The motion carried.

Representative Lane made a motion for the passage of HB 3028 as amended. Representative Buehler seconded the motion. The motion carried.

HB 2936: Workers compensation, coverage of persons performing community service work while assigned to a conservation camp

Representative Crumbaker proposed to change the word "physician" to "health care providers". Jim Wilson explained that if we change the wording in this bill we should change it in all other workers compensation bills so that they will be consistent.

Representative Green made a motion to change the word "physician" to "health care providers" Representative Lynch seconded the motion. The motion carried.

Representative Patrick made a substitute motion to pass HB 2936 without the amendment. Representative Hensley seconded the motion. The motion carried.

HB 3069: Concerning the workers compensation act

Jim Schwartz, Kansas Employee Coalition on Health, spoke as a proponent to the bill, Attachment #4. He stated that the health care industry is the only one in which the vendors control both the number of services delivered and the unit price of those services. There are no generally accepted standards that exist to test whether fees are even within the normal range. While no state regulates physician fees for private health insurance, half do for workers compensation.

Representative Webb asked how are we going to save the money, are we going to have less care for the injured worker. Mr. Schwartz replied that the highest 15% of the doctors fees will be where the fee schedule line is drawn.

Representative Patrick said that he feels that the insurance companies have no incentive to hold cost down. Mr. Schwartz stated the Kansas Employer Coalition on Health has a proposal issued for that reason called "Comprehensive Improvements to the Healthcare Financing and Delivery Systems", Attachment #5.

The meeting adjourned at 9:55 a.m. The next meeting of the committee is scheduled for March 1, 1990 at 9:00 a.m. in room 526-S.

GUEST LIST

COMMITTEE: House Labor + Industry DATE: Feb. 28, 1990

NAME	ADDRESS	COMPANY/ORGANIZATION
E. B. SIFERS	S. M. KS.	
Charles V. Simpson	Topeka	KFMC
Jim Schwerdtfeger	Topeka	KECH
RICHARD THOMAS RICHARDSON	TOPEKA	DHR/WC
John M. Ochrowski	Topeka	AFL-CIO
David A Shufelt	Topeka	DHR/Div. Work Comp
Ken Bahr	Topeka	Charter Hospital
C. Rieman	TOPEKA	KAOM
B. Williams	Topeka	Ks Pharmacists Assn.
C Dodson	TOPEKA	KAPE
Chip Wheelen	Topeka	Ks Medical Soc.
Phillip Davidson	Topeka	Ks. Dept. of Rev.
Bob Anderson	"	Ks. Chiropractic Assoc.
Don Linosey	Osawatomie	UTU
Katharine Mendenhall	Topeka	KASB

KANSAS DEPARTMENT OF HUMAN RESOURCES

DIVISION OF WORKERS COMPENSATION
600 Merchants Bank Tower, 800 SW Jackson
Topeka, Kansas 66612-1227
(General Information: 913-296-3441)

Mike Hayden, Governor

Ray D. Siehndel, Secretary

296-4000 Director's Office
296-2050 Rehabilitation
296-2996 Claims Advisory
296-3606 Self Insurance
296-7012 Law Judges

February 26, 1990

The Honorable Arthur Douville
Chairman, House Labor & Industry Committee
State Capitol, Room 115-S
Topeka, KS 66612

Re: House Bill 3028

Dear Chairman Douville:

Thank you for allowing me to appear before your committee today and testify in support of House Bill 3028.

House Bill 3028 is the proposed amendment to K.S.A. 44-510g that is the unanimous recommendation of the Workers Compensation Joint Advisory Committee. As you know, Ray Siehndel, Secretary of Human Resources appointed a Workers Compensation Joint Advisory Committee in August 1989 after a 13 year absence to study the "New Act" and to make recommendations for any amendments to the Kansas Legislature during the 1990 Legislative Session.

The full Joint Advisory Committee met four time between August 1989 and January 1990 and a subcommittee formed during the October 27, 1989, meeting met a fifth time to draft a proposal for the advisory committee's approval, to recommend to the 1990 legislature that K.S.A. 44-510g(e)(b) be amended to strike the language that limits temporary total or temporary partial compensation paid solely because of involvement in the rehabilitation process to a maximum of 100 days.

The Workers Compensation Joint Advisory Committee had 16 members; two representing labor; two representing industry; two representing insurance; two at-large; a claimant's attorney; a respondent's attorney; a Fund attorney; two rehabilitation vendors; two self-insured; and, a physician. A list of the committee members is attached for your reference.

House Labor & Industry
Attachment #1
02-28-90

As an ex-officio member of the Workers Compensation Joint Advisory Committee, I am pleased to forward the unanimous committee's recommendation that HB 3028 be adopted as an amendment by the House Labor & Industry Committee.

If passed, HB 3028 would codify several legal interpretations that I have rendered concerning vocational rehabilitation since July 1, 1988. Those are that (1) the "date of evaluation" mentioned in 44-510g(e)(2)(b) from which temporary total disability compensation is to be paid is the date the injured worker is referred to a vendor for vocational assessment; and (2) administrative law judges have authority when ordering vocational rehabilitation evaluation report to order respondent to pay temporary total disability compensation prior to compensation of the assessment.

HB 3028 strikes the language that limited the maximum time which a claimant could receive temporary total or temporary partial compensation solely because of involvement in the rehabilitation evaluation process. (Subsection B)

HB 3028 also codifies the right of the employer to select the qualified agency or facility (vendor); if the selection is made by the employer within 15 days after receipt of an order issued by an administrative law judge or a notification by the rehabilitation administrator that the vocational assessment, rehabilitation, reeducation or training is needed for the employee (Subsection K)

HB 3028 also provides for a procedure to change a vendor after a review for good cause shown by substantial evidence. The respondent will provide the employee with a list of three from which the employee shall choose the replacement. (Subsection 1)

HB 3028 also provides for a change of vendors if there is an agreement by all parties to make such replacement.

HB 3028 also inserts the word "assessment" and strikes the word "evaluation" in various subsections in an effort to clarify the rehabilitation process.

In HB 3069, in subsection 6(1), the definition of "assessment" was inadvertently placed in K.S.A. 44-510g. It was intended that the new language become subsection (N) of HB 3028 and I am offering a balloon amendment and ask that this committee approve the additional subsection (N) if they vote to pass HB 3028. A copy of the "balloon amendment" is attached.

Thank you for allowing me to appear on behalf of the Workers Compensation Joint Advisory Committee and testify in support of HB 3028.

Yours truly,

Robert A. Anderson

Robert A. Anderson
Workers Compensation Director

mr

Enclosures

pc: Ray D. Siehndel, Secretary of Human Resources

this section and the employee shall select a replacement from such list.

(m) Any qualified agency or facility providing vocational assessment, rehabilitation, reeducation or training under this section may be replaced by another such qualified agency or facility upon written notice by all parties, including the rehabilitation administrator, if there is an agreement by all parties to make such replacement.

Sec. 2. K.S.A. 1989 Supp. 44-510g is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the Kansas register.

(N) As used in this section, "assessment" means the process of determining services and the vocational potential of the injured worker. The assessment process includes the appointment of a rehabilitation vendor to review the injured worker's medical restrictions, education, experience and training, the worker's aptitude and abilities, and the job the worker was doing at the time of injury. The assessment must include a documented decision of the need for vocational rehabilitation services, and if needed, an individualized rehabilitation plan that identifies realistic vocational goals. The assessment must identify the obstacles to returning to a comparable wage position in the open labor market and the plan must provide a step-by-step procedure that will either circumvent or alleviate the obstacles identified in the counselor's determination that services are needed.

WORKERS COMPENSATION JOINT ADVISORY COMMITTEE MEMBERS

October, 1989

	Name/Address	Organization/Occupation	Representing
1.	Wayne Maichel P.O. Box 1455 Topeka, Kansas 66601 (913) 357-0396	Kansas AFL/CIO	Labor
2.	John Ostrowski P.O. Box 1453 Topeka, Kansas 66601 (913) 233-2323	Attorney/Lobbyist	Labor
3.	Terry Leatherman 500 Bank IV Tower One Townsite Plaza Topeka, Kansas 66603-3460 (913) 357-6321	KCCI	Industry
4.	Rob Hodges 700 S.W. Jackson, Suite 704 Topeka, Kansas 66603 (913) 234-0307	Ks. Telecommunications Asso.	Industry
5.	Ken Jones P.O. Box 1739 Wichita, Kansas 67201 (316) 685-5471	Employers Mutual Ins.	Insurance
6.	Jack Stewart P.O. Box 2954 Overland Park, Kansas 66201 (913) 451-1570	St. Paul Ins. Cos.	Insurance
7.	J. Richard Amend P.O. Box 206 Wichita, Kansas 67201 (316) 263-3211	Dulaney, Johnston & Priest	At-Large
8.	Chris Allen P.O. Box 7600 Overland Park, Kansas 66207 (913) 345-1776	Royal Insurance Co.	At-Large
9.	Norman Cooley 608 North Broadway Wichita, Kansas 67214 (316) 265-2978	Attorney	Claimant's Atty.

House Labor & Industry
Attachment #3
02-28-90

10. Randall Palmer P.O. Box 1101 Pittsburg, Kansas 66762 (316) 231-9890	Attorney	Respondent's Atty.
11. Chris Cowger 420 S.W. 9th Street Topeka, Kansas 66612 (913) 296-2188	Ks. Insurance Department	Fund Attorney
12. Bruce Smith 7070 W. 107th Street, Ste. 160 Overland Park, Kansas 66212 (913) 381-0081	Prof. Rehab. Consul.	Rehab. Vendor
13. S. M. Kiegerl P.O. Box 847 Olathe, Kansas 66061 (913) 782-6697	Prof. Rehab. Management	Rehab. Vendor
14. Terry Bernatis 900 S.W. Jackson, Rm. 951-S Topeka, Kansas 66612 (913) 296-4278	Bnfts. Analysis Manager (State Self-Ins. Fund)	Self-Insureds
15. Mike Cavell 220 East 6th Street, Rm. 515 Topeka, Kansas 66603 (913) 276-8413	Southwestern Bell	Self-Insureds
16. Charles White, M.D. 818 North Emporia, Ste. 107 Wichita, Kansas 67214-3725 (316) 291-7246	Mid-West Pain Mgemt. Ctr.	Physician
17. Richard Thomas 900 S.W. Jackson, Rm. 651-S Topeka, Kansas 66612 (913) 296-3441	Rehab. Administrator (Div. of Workers Comp.)	Ex Officio
18. Robert Anderson 900 S.W. Jackson, Rm. 651-S Topeka, Kansas 66612 (913) 296-3441	Director (Div. of Workers Comp.)	Ex Officio

WORKERS COMPENSATION REHABILITATION
ADVISORY COMMITTEE
JUNE 1989

NAME/ADDRESS	ORGANIZATION
Richard L. Thomas 900 SW Jackson, Room 651-S Landon State Office Building Topeka, Kansas 66612 (913) 296-3441	Rehabilitation Administrator Workers Compensation
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(913) 296-3441

Assistant Director
Workers Compensation

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

Kansas Employer Coalition on Health
Testimony to the House Labor and Industry Committee
re: H-3069 (Medical Fee Schedules for Workers' Compensation)
February 27, 1990

by Jim Schwartz, Consulting Director

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The coalition is over 100 companies across the state who share a concern about the soaring cost of health care provided to employees. Last year I also was honored to serve as Chairman of the Task Force to Evaluate Medical Fee Schedules and Cost-Containment for Workers' Compensation in Kansas.

Princeton Economist Uwe Reinhardt makes an interesting point. He observes that among American industries, a special situation exists with respect to the health care industry: it is the only one in which the vendors control both the number of services delivered *and* the unit price of those services. This is so because doctors (not patients) are largely in charge of ordering the tests, drugs, hospitalizations, treatments and return visits of their clients. The same doctors then assign a fee that they feel to be appropriate and expect payment without rancor.

Increasingly, insurers are questioning the amount and prices of health care services. Except in the area of workers' compensation. In that area no generally accepted standard (such as "reasonable and customary") exists to test whether fees are even within normal ranges.

In the absense of any meaningful restraints, the cost of workers' compensation medical claims has risen even faster than the dizzying pace of health insurance claims. Only because work-comp costs are still smaller than health plan costs, do we generally hear less about them. But the trend, as you have heard already, is shocking.

Now what can be done to turn this problem around? Everyone agrees that employers and insurers can and must do more to apply to workers' compensation the techniques that tend to retard healthcare inflation for group plans. Utilization review, large case management and PPOs are a few examples. But there is also good agreement among experts that competitive pressures alone will not be enough. Not for group plans, not for workers' compensation. Some regulation will be required.

In the case of workers' compensation, the expectation of a regulatory role is well established. That comes about because workers' compensation is broadly and correctly perceived as a highly regulated, mandatory social compact. And while no state regulates physician fees for private health insurance, half now do for work-comp.

We recognize that the work-comp director has authority to implement a fee schedule without legislative requirement. This coalition nonetheless supports a statutory framework for such an initiative. The reasons are 1) a bill like this sends a strong message about the seriousness of the cost problem and 2) a fee schedule implemented under such a law is likely to be more durable.

The stakes are very high. Work-comp conditions constitute a touchstone for businesses considering locations in Kansas. So it makes sense for the public and private sectors to join in a concerted effort to keep our workers' compensation costs in line. We need your help in implementing this modest and conservative regulation of high-end provider fees.

Discussion Draft #4

KANSAS EMPLOYER COALITION ON HEALTH, INC. PROPOSAL FOR COMPREHENSIVE IMPROVEMENTS TO THE HEALTHCARE FINANCING AND DELIVERY SYSTEMS

February, 1990

Abstract:

A sub-committee of the Kansas Employer Coalition on Health has prepared recommendations for alleviating the problems of rising cost, inequitable access, and variable quality, which are endemic to the present healthcare funding and delivery systems throughout the United States, including Kansas. The recommendations constitute a comprehensive approach to restructuring the system on a state or federal level, yet build on existing institutions and systems to a large extent.

The primary components of the proposal are requirements for 1) universal health insurance coverage through employer-based plans and a publicly sponsored plan, 2) regulation of insurance rate increases by a formula closely tracking the CPI, 3) required uniformity of premium rates within each plan (community rating), 4) required acceptance by insurance plans of any applying employer group, 5) quality monitoring and support for medical research into preferred methods of treatment (protocols), and 6) reform of the medical malpractice laws.

Background

The present methods of funding and delivering healthcare in Kansas (and throughout most of the United States) have allowed or contributed to the emergence of several serious problems:

1) Healthcare costs have increased at an alarming rate throughout the 1980's, far outstripping the overall inflation rate and doubling approximately every five years.

2) An estimated 500,000 Kansans (over 30 million Americans) are without any insurance against the cost of medical care, a condition that leads to uncompensated services by providers and an undesirable level of cost-shifting to paying patients.

3) Morbidity and mortality statistics for the United States are unenviable compared to those of other developed countries, despite this country's leading role in healthcare spending.

The urgency behind efforts to solve these problems is nowhere as evident as in the case of cost inflation. Even under optimistic assumptions about attenuation of the current trends, cost projections for the year 2000 appear prohibitive. If current trends are projected, future costs will be truly staggering.

	Average Annual Insurance Inflation Rate				
Year	10%	15%	20%	25%	30%
1990	$400	$400	$400	$400	$400
'91	440	460	480	500	520
'92	484	529	576	625	676
'93	532	608	691	781	879
'94	586	700	829	977	1,142
'95	644	805	995	1,221	1,485
'96	709	925	1,194	1,526	1,931
'97	779	1,064	1,433	1,907	2,510
'98	857	1,224	1,720	2,384	3,263
'99	943	1,407	2,064	2,980	4,242
2000	$1,037	$1,618	$2,477	$3,725	$5,514

Effect of Health Insurance Inflation Factors on Family Policy Rates

Healthcare observers generally agree that market forces of the 1980's have failed to deal successfully and permanently with these problems. In response, members of the KECH Governmental Affairs Committee created a subcommittee to seek other long-term solutions to the problems.

The Long-Term Solutions Subcommittee was constituted in April, 1989, represented by two member each from business, insurance, and providers (with assistance from KECH staff).

The group began by identifying the major problems facing healthcare purchasers today. The problems of cost, access, quality and demand were explored in considerable detail. Particular attention was placed on the question of why supply/demand economic forces had failed to control healthcare costs. Many answers to that question emerged, including 1) separation of payer and vendor by virtue of insurance, 2) ability of some patients to receive treatment without paying, 3) provider-created demand for services (providers influence the amount of care dispensed), 4) commonplace attitudes among patients that only the best care is acceptable and that more care is better care, 5) lack of usable data for consumers on prices and quality of services, 6) a lack of rational consumerism on the part of sick and frightened patients, and 7) consumers often view the system as being responsible for curing them and do not accept responsibility for their lifestyles and health.

Why have competitive forces failed to control costs?

- ❖ separation of payer and vendor by virtue of insurance;
- ❖ ability of some patients to receive treatment without paying;
- ❖ provider-created demand for services (providers influence the amount of care dispensed);
- ❖ commonplace attitudes among patients that only the best care is acceptable and that more care is better care;
- ❖ lack of usable data for consumers on prices and quality of services;
- ❖ a lack of rational consumerism on the part of sick and frightened patients;
- ❖ consumers' view of the system as being responsible for curing them, without accepting responsibility for their lifestyles and health.

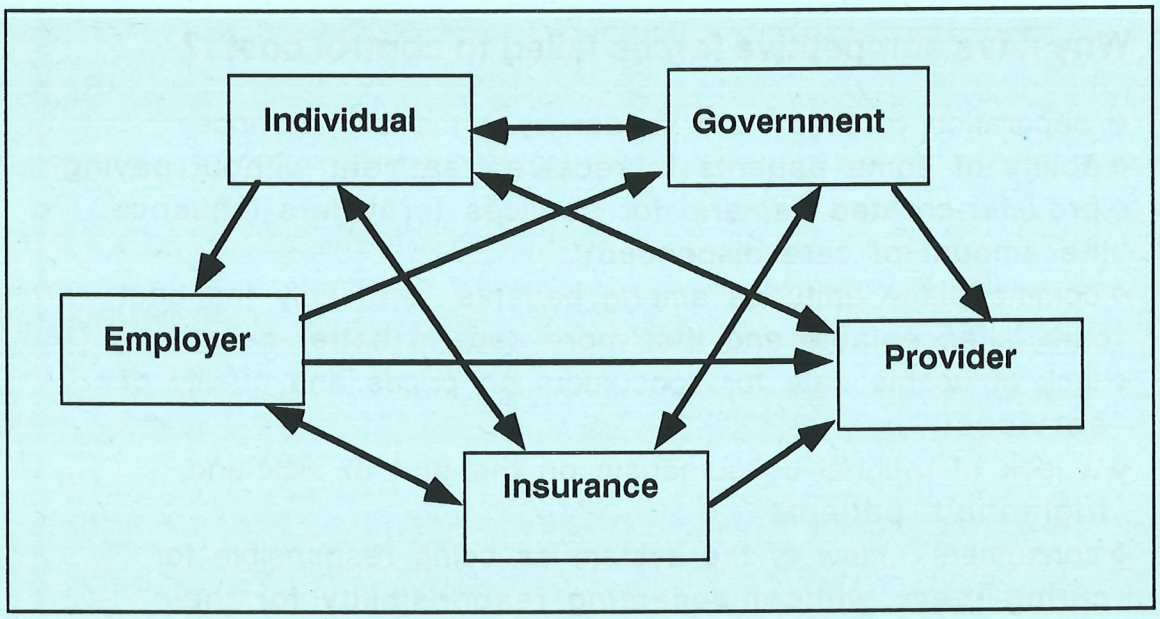
The group explored domestic proposals for reform, as well as a number of foreign systems: Canadian, western European and Pacific rim. Because of cultural differences between these countries and the United States, none of these systems appeared directly applicable to this country.

A consensus emerged within the group that the problems of cost, access and quality are interrelated. Further, the group came to view the prospects for long-term solutions as more favorable within the context of a comprehensive restructuring of the system; simply expanding the current system and amplifying present cost-containment techniques would likely prove inadequate. The

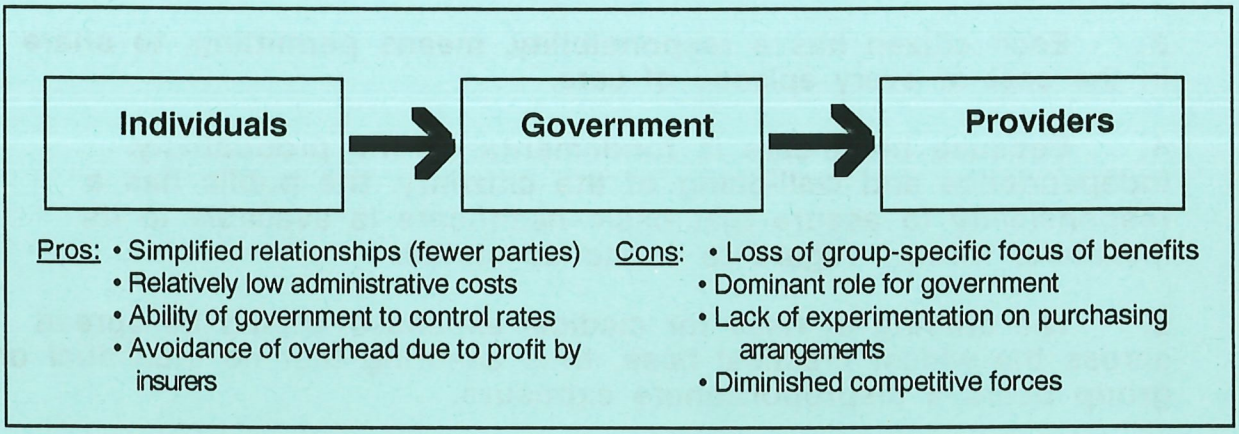
committee felt that a comprehensive reform could succeed on a state level but that a national initiative would be preferable because such an approach might deal better with the problems of conflicting federal laws and multi-state logistics.

Agreement was reached that lasting solutions must include making difficult choices. Those choices must be based on funding priorities for competing societal needs, including housing, education, defense, transportation, and retirement security, to name only a few. Given that funding available for healthcare is finite, some rational method must be devised to assure that healthcare resources are applied so as to render the best possible health outcomes for the dollar—for the citizenry as a whole. Such a choice carries with it the result that not all possible services will be funded; services of marginal value would have to be sacrificed in favor of those that give more benefit for the expense.

The committee recognized that the funding relationships in the present system carry a heavy burden of administrative complexity. In addition, the diffusion of purchasing authority detracts from clout necessary to control costs.



Flow of funds in the "pluralistic" US healthcare system



Flow of Funds in a Typical Single-Payer Health Insurance System

The group came to recognize that a healthcare system involving a single payer has advantages in terms of administrative streamlining and clout for controlling costs. At the same time, it was acknowledged that since the single payer would likely be government, any proposal for such a system would have to contend with a deep skepticism in U.S. society about government's ability to operate such a sensitive system.

Determined to begin with an approach that minimizes the role of government and yet achieves reform of the system, the committee agreed that an evolutionary approach—building on existing foundations—is desirable, possible and, in all likelihood, politically necessary. The goal became to envision new relationships among existing players such that 1) competitive forces operate to trim and energize the system and 2) governmental activities are limited to the issuance of a few simple rules.

If, however, reform such as that proposed here, retaining multiple payers, fails to contain costs, then a single-payer system involving a stronger governmental role will likely be required.

After many months of discussion, the group concurred on a set of principles on which to base action. Those principles, tempered by recognition of some political realities, societal constraints, and a spirit of give and take, led to the formation of a set of recommendations for restructuring the state or national healthcare funding and delivery systems.

Principles

1. Each citizen or citizen's family has a responsibility to secure financial protection against major healthcare costs and so should participate in a comprehensive plan of health insurance.

2. Each citizen has a responsibility, means permitting, to share in the cost of his or her insurance plan.

3. Each citizen has a responsibility, means permitting, to share in the cost of every episode of care.

4. Because healthcare is fundamental to the productivity, independence and well-being of the citizenry, the public has a responsibility to assure that basic healthcare is available to its members, without regard to economic status.

5. The sharing of risks for medical expenses should be spread across the widest practical base, thus assuring that no individual or group bears a disproportionate exposure.

6. Proposals for system reform should build upon current structures to a maximum extent consistent with achieving control of costs, access and quality.

7. Proposals for system reform should minimize reliance on regulatory controls, consistent with goals for costs, access and quality.

Recommendations and Rationale

1) Require each citizen to subscribe to a broad plan of health insurance coverage.

The group concluded after much debate that healthcare is perceived by the American public as fundamental to the productivity, independence, and well-being of the citizenry. In order to secure such a basic good, the public has a responsibility to assure that a reasonable level of healthcare is available to all its members, without regard to economic status. Committee members who doubted the responsibility of society to individuals in this regard still tended to concede the value to society of providing basic treatment in order to prevent expensive emergency care.

With these precepts in mind, the committee agreed that a key tenant of the proposal is to require each citizen to subscribe to a broad plan of health insurance coverage.

At first the committee wanted to limit the scope of required coverage to some narrow, "basic" range of services. Then, however, the group came to realize that whatever cost-containment strategy was employed, it could succeed only to the extent that the health plan has breadth. Failing to make the coverage broad simply invites continued escalation of costs for uncovered services.

With that premise in mind, the committee agreed that the required breadth of coverage should be similar to that of the HMO Act or Medicare.

Notwithstanding serious reservations about the appropriateness and utility of having employers sponsor health plans, the group felt that an evolutionary approach to achieving universal coverage would likely start with existing employer-insurance relationships. Under the committee's recommended approach, employers would have the option to either provide coverage or pay a tax to help support a publicly sponsored plan.

Individuals would be required to help support their plan participation through either premium sharing (in the case of employer-sponsored plans) or taxation (in the case of the publicly sponsored plan). Currently, many uninsured individuals are those who could afford to contribute to the cost of insurance. When they incur major medical expenses, their expenses must be shifted to the insured population. Thus by requiring individual participation in the cost of insurance, costs would more equitably be spread among those who are able to bear them. Moreover, a requirement for individual premium sharing would make patients more cognizant of costs and, presumably, wiser purchasers of care.

Detailed funding schemes that satisfy these requirements have been articulated by the National Leadership Commission on Health Care[1] and Enthoven [2].

The publicly sponsored plan could be managed directly by the state (or federal government) or indirectly through fiscal intermediaries who would bid for contracts. State Medicaid programs could be folded into the public plan.

Taxes on individuals for the publicly sponsored plan would reflect income (and perhaps asset) level, probably with some realistic cap on taxable amount.

The committee expects that market forces will maintain a strong commitment by employers to providing coverage. Those forces include the need to attract labor by offering a contribution to insurance premiums and tax deductibility of those contributions. In addition, employers would be free to offer private, supplemental insurance for conditions not covered in the basic plan.

2) Require the state (or the federal government) to determine a single maximum annual percentage of premium increase (or taxation increase in the case of the publicly sponsored plan) for all H.I. plans.

The committee agreed that the concept of a budget is fundamental to healthcare cost containment. An expeditious way to achieve a budget without inviting government to assign roles and apportion resources would be to require the state (or the federal government) to determine a single maximum annual

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[1] *For the Health of a Nation.* National Leadership Commission on Health Care. Health Administration Press, a Division of the Foundation of the American College of Healthcare Executives. January 1989.

[2] *A Consumer-Choice Health Plan for the 1990's.* Alain Enthoven and Richard Kronick. New England Journal of Medicine, Vol. 320, No. 1, 1989.

percentage of premium increase (or taxation increase in the case of the publicly sponsored plan) for all H.I. plans.

The rate adjustment would be determined by a formula closely tracking the Consumer Price Index. The reason for not limiting the increases strictly to the CPI is that some latitude may be needed 1) to fund general medical research and research on protocols (see item #3, below), 2) for funding improved technology, and 3) to reflect changes in the injury/illness patterns of society. A separate pool made up of all carriers could be created to fund widespread catastrophes or unpredictable epidemics.

This requirement for limiting increases in insurance rates effectively establishes a budget for the system. Experience has taught that when the healthcare system is constrained in a particular direction, it tends to bulge out in another direction. Thus the group felt that only through establishing a budget for the entire system could expansion of the system be controlled.

The effect of limiting rate increases would be to place insurers at risk for increasing costs. Thus insurers would have a powerful incentive to control costs. The committee believes that a natural reaction by insurers would be to form tightly integrated managed-care alliances with providers in order to share the financial risk with those providers. Careful cost/benefit judgements would be required of insurers and their provider allies in determining such matters as capital expansion, preference among treatment locations and modalities, length of confinement, and selection of materials and subcontractors. Providers who fail to help the plan stay within budget would be less attractive to plan sponsors.

The committee expects that such rate regulation would probably force a consolidation of the health insurance industry from the hundreds now licensed in Kansas to those that can develop the capability to manage costs. Indeed, insurers may eventually become the financing and marketing arms of the delivery system.

All of these changes are desirable from the standpoint of reducing the administrative overhead associated with the present fragmented system. In addition, this strategy creates incentives to apply provider compensation methods that reward cost-effective behavior. For example, fee-for-service plans would be expected to give way to plans that pay providers by salary, per patient or per case. Where fees are paid, fee schedules and expenditure targets would be employed.

A politically attractive aspect of this strategy is that desirable economic changes are encouraged simply by limiting the pot of funds available for care. The market will then attend to realignment, without need for sweeping government intervention.

3) Quality of healthcare services will be assured through government monitoring and establishment of publicly sponsored research on medical protocols.

When cost containment is discussed, providers often warn about the possibility that quality will suffer. The committee is sensitive to pressures for diminished quality when financing is limited. Thus the committee affirms its belief that providers should be accountable for an acceptable level of quality. To guard against deteriorating quality, the committee recommends that government monitor quality of medical services and make reports available to the public. In addition, a portion of the taxes on employers, insurers and individuals should be earmarked for research on medical protocols. The reason for this last item is that there is wide variation in practice styles, unsupported by evidence of differing effectiveness or outcomes. Research on protocols would help clarify some of the "gray areas" in medicine and raise some of the "art" to the level of science.

4) Require insurers to community-rate their groups.

The health insurance industry began with the concept that costs should be spread among many people, so that no individual would risk financial devastation from health care expenses. Early insurance plans charged the same rate for all groups within a given community. This practice became known as "community rating."

Eventually some groups discovered that through good fortune their members were unusually healthy and so needed less care than those of other groups. They found carriers who would rate them according to their exceptionally low-cost experience. Having lost these low-cost members, the original plans quickly found their costs per beneficiary much higher and so needed to raise premiums.

This trend of splitting the healthy from the unhealthy has continued until the cost of insurance for some less-healthy groups has become unaffordable. Even seemingly innocuous practices such as rating groups by age and sex may effectively shift costs toward the most needy. The offering of multiple options within groups has further aggravated this situation. Worse yet, some groups have resorted to questionable practices like excluding seriously ill members from the plan to keep costs in line.

If one accepts the premise that the public has a responsibility to assure it members a reasonable level of care, regardless of economic status, then it follows that systemic reform must restore the practice of well people shouldering the financial burden imposed on the ill and aged. Experience rating, by contrast, tends to shift costs to the ill, injured and aging — often the people least able to cope with such demands. Thus the committee includes in its proposal a requirement for community rating, meaning a single set of rates based only on dependent status and the broadest practical geographic basis.

To fully realize the system-wide benefits of community rating, the ability of individual companies to splinter off from the community and pay only for preferred risks would have to be minimized. Thus it is recommended that self-insured plans be gradually phased out. The potential long-run costs of self-

insurance under the current system are likely to be much greater than the long-run costs associated with participation in a community-rated plan with costs controlled as outlined in this proposal.

The committee recognized that any weakening of the concepts of experience rating or self-insurance would tend to reduce savings to the insurance plan attributable to corporate health promotion. Several countervailing arguments are in order here. First, the record of direct savings to health plans stemming from corporate health promotion programs suggests that savings are difficult to measure and are usually modest. Many consultants suggest operating such programs not for their potential savings to the insurance plan but for improved productivity, attendance and morale. Second, the high turnover rate in many industries limits the ability of health promotion programs to reap rewards for the sponsoring firm. This situation arises because the benefits to health promotion on health status are generally slow to manifest. The long-term nature of health promotion argues instead for community rating, coupled with public health education, so that improvements to health status would apply to the plan despite turnover in employment.

After weighing these trade-offs, the committee concurred that the net advantages of a strategy that includes community rating, taken as a whole, outweigh the loss of savings through health promotion by isolated plans.

In order to stabilize community-rated pools, a "shock claim" or "catastrophic claim" pool could be sponsored by all insurers in the community. This fund would ensure that major claims are spread over the widest possible base.

5) Require insurers to quote and accept any employer group or association of employer groups that applies, within capacity limits.

Some groups presently encounter an extreme form of experience rating: not by premium levels, but by exclusion at any price. There is currently much financial pressure on insurers to "skim" the healthiest risks from the available population. Thus it is commonplace for insurers to refuse to write coverage for groups with high claims histories—or to cancel groups that develop such records. The effect of such practices is to segregate the ill from the able, which benefits the able at the expense of the unfortunate. For the same reasons presented for recommendation #4 above, the committee recommends that insurers be required to accept any employer-based group (or association of employer groups) that applies.

6) Require each patient or patient's family, means permitting, to pay some fee for every episode of care, up to some out-of-pocket maximum.

The group felt that efforts to contain the overall costs of healthcare must address demand by individuals. The first Rand Corporation study showed that medical services perceived as "free" tend to be utilized at a greater rate than those that bear some cost to the recipient. Many current insurance plans pay all or nearly

all of the cost of treatment. Others share costs primarily through deductibles, which are often removed in time (and thus in mind) from the act of requesting services.

7) Require ancillary activities by government.

To provide a context for reform, government should provide leadership to develop healthcare policy -- on a national, regional and state level.

Since prevention is the best medicine and education is the key to prevention, government should provide improved health education services to the public.

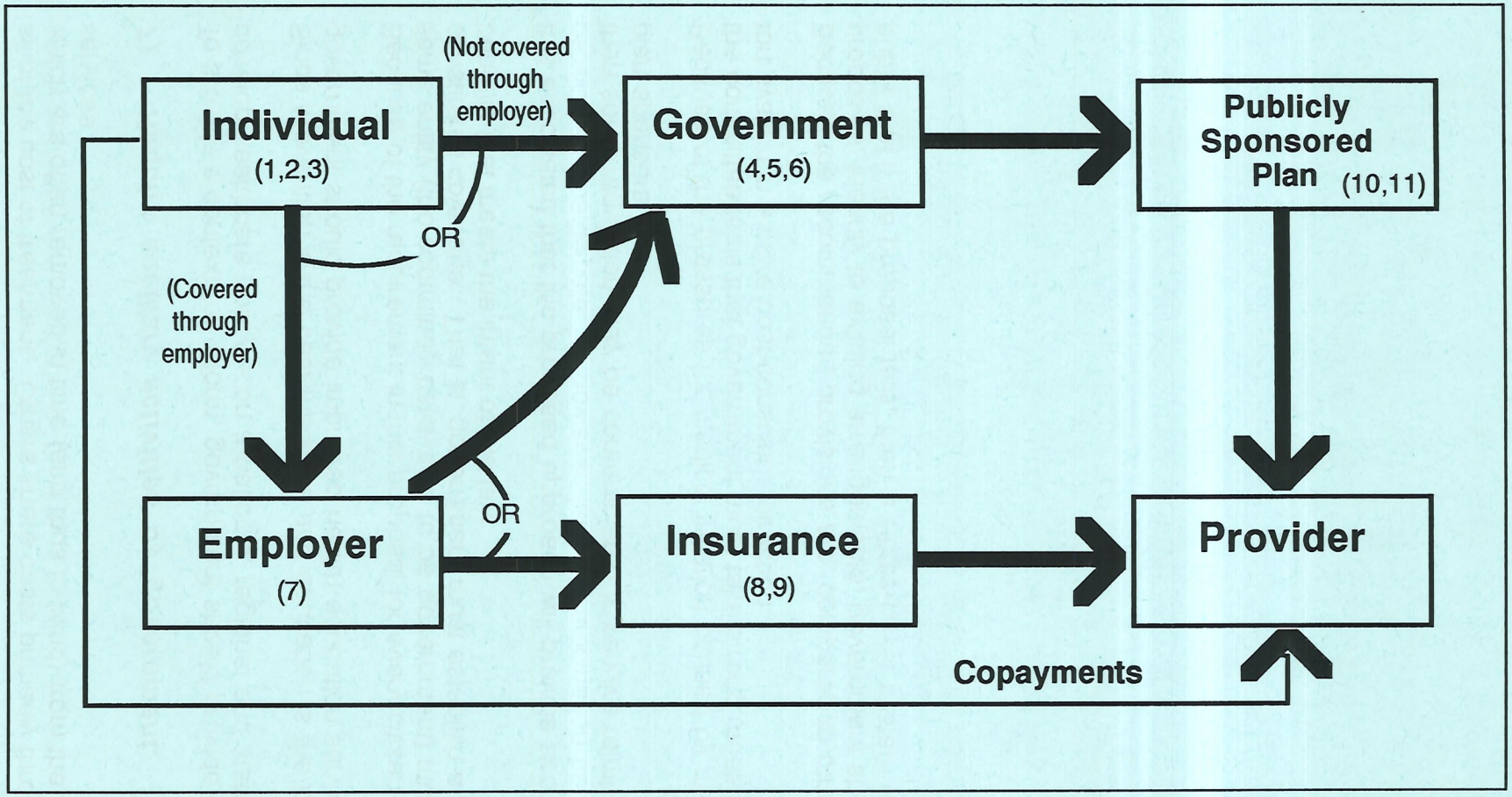
Because of the requirement in this proposal for every citizen to carry coverage, some entity (the committee believes it to be government) must establish what constitutes coverage. That is, government must establish a minimum level of benefits that meets the intent of the law.

It is anticipated that the proposed approach will provide strong incentives for providers to participate. If, however, lack of participation becomes a problem then some regulation may be contemplated to require reimbursement through plan sponsors.

Because of the pressures for medical inflation caused by malpractice litigation, the committee feels that government must take strong measures to reform the tort system in a more cost-conscious direction.

Because the recommended provisions are, compared to other reform proposals, friendly to existing arrangements, government should inform the public that if the proposal fails, then a single-payer system will be implemented.

Simplified Overview of the Flow of Funds



1) Mandatory coverage through either an employer-sponsored plan or a publicly sponsored plan.
2) Out-of-pocket payment for each episode of care, according to ability to pay.
3) Payment of some portion of premium for employer's plan — or payment of tax toward publicly sponsored plan.
4) Regulation of maximum allowable premium increases.
5) Quality monitoring and support for protocol research.
6) Reform of tort system.
7) Option to provide coverage or pay tax toward publicly sponsored plan.
8) Required "community rating."
9) Required acceptance of any applying employer group.
10) Because of sliding scale and worse risk for this group, subsidy will be required through tax or else surcharge on other insurance.
11) Operation could be be any of several means, e.g. contracted administration, contracted inclusion in carriers' lines, or direct government operation.