Approved 2-12-91
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader at
Chairperson

1:30 /a.m./p.m. on February 11, 1991 in room 423-S of the Capitol.

All members were present except:

Representative Theo Cribbs, excused
Representative Scott, excused

Committee staff present:

Sue Hill, Committee Secretary

Conferees appearing before the committee:

Jeffrey Ellis, Governor's Commission on Health Care
C. Wayne Johnston, Governor's Commission on Health Care
Barbara Gibson, Governor's Commission on Health Care

Chairperson Sader called meeting to order, introducing a former State Representative and former member of the Committee on Public Health and Welfare, Kenneth Green from Eldorado. He was warmly welcomed. Mr. Green said, "it is good to see familiar faces, and he was happy to be on this committee for a long time, and he knew this new committee would do a great job." He asked that the retarded children be given good consideration. Chair welcomed Mr. Green and all others present today.

Chair drew attention to committee minutes, then paused while members read them carefully.

Rep. Tom Bishop moved minutes of February 6, and February 7 be approved as presented, motion seconded by Rep. Weiland, motion carried.

Chair drew attention to Report of the Governor's Health Care Commission to be presented today and recognized presentors.

Mr. Jeff Ellis offered hand-out (Attachment No. 1), his printed testimony. Mr. Ellis also had a graphics display with slides. Testimony was detailed and informative. He spoke of the challenges in health care for the 1990's; rising costs of health care; explained how health benefit costs have expanded and reasons for same. Mr. Ellis spoke of the health care costs of corporate America and how this has changed the cost structure of health care. The Governor's Commission on Health Care recognizes the magnitude of the health care crisis in this country. Mr. Ellis then highlighted numerous Commission recommendations. He answered numerous questions. (Note: - Report and Recommendations of the Kansas Governor's Health Care Commission is not filed as an Attachment, but is on file in offices of Research Department).

C. Wayne Johnston, member of the Governor's Commission on Kansas Health Care spoke about the issue of insurance and the finance portions of this report. He called attention to pages 20, 21, 22 in Report. He spoke of insurance reforms, i.e., and outlined Phase 1, II, III of plans proposed. Phase I would result in an approach to make coverage available for small groups or businesses. Phase II, would expand availability of coverage beyond small groups to include the unemployed under age 65, the self-employed, and medically uninsurable individuals. He gave a comprehensive explanation of these recommendations. He also highlighted options, i.e., all insurers assume part of the risk pool; premium charge cannot exceed 150% of normal health insurance rates; standard agreed-to benefit program. Phase III, was recommended for future implementation and designed to assure universal access to health care coverage. He gave a comprehensive report, and answered numerous questions.

Barbara J. Gibson, member of Governor's Commission on Kansas Health Care, stated that with 50 members serving on the Commission, it was possible to have most special interests represented. Therefore most concerns could be reviewed. They searched for solutions that were practical and implementable. People are in fact yelling out the window, "I'm damn mad, and I won't put up with this anymore", and they define what they are not willing to put up with. Trade-offs are necessary, so they began to deal with how this could be implemented. The health care situation is not just a problem--it is a dilemma. A process of solutions is needed, not a solution to a problem. Federal solution is not on the immediate horizon, so the responsibility falls to the States. Ms. Gibson discussed efforts to elevate access to health care, costs, quality care and the difficulty in balancing these problems. She answered numerous questions.

Mr. Ellis then thanked Chair and Committee for the opportunity to make their remarks today. He stated the Commission had worked very hard on a complex and conflicting task. He urged members to read over the Report and not let all this work be unanswered. He noted the pieces of this puzzle can all fit together, it will take more work, part of which this Committee can do.

Mr. Ellis introduced Mr. Bill Dean who was also an important member of the Commission.

Chair thanked all speakers for their testimony, and assured them that their comments are extremely valuable and would be carefully considered.

Chair adjourned meeting 3:02 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Feb 11th

NAME	ORGANIZATION	ADDRESS
[illegible] Green	Visitor	El Dorado Ks
Karolynne Thomas	Close Up Kansas	217 W. Bradley Sedan, Ks
Katie Dill	Close Up Kansas	417 N. Chautauqua Sedan
Katie Klassen	SRS	Topeka
Wayne Johnston	Retired	Topeka
[illegible]	Gov Comm Health Care	KC
Barbara Gibson	Gov Comm on Health Care	Hutchinson
Marilyn Bradt	KINH	Lawrence
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
GARY Robbins	Ks Opt Assn	Topeka
Martha Gabehart	Ks. Comm on Disability Conc.	Topeka
Ken Baker	Ks. Hospital Assn.	Topeka
NANCY Groman	Close-Up -Ks	SEDAN
Jason Floyd	Close-Up -KANSAS	SEDAN
David Hanzlick	FDA	Topeka
LeeJene Schneider	HIAA / State Farm	Topeka
Nancy Zogleman	BC/BS of Ks	Topeka
Max Hailey	Kansas Chapter, ACS	Topeka
MIKE Wojcicki	~~TOPEKA~~ DOB	~~DO~~ TOPEKA
Paul Johnson	PACK	Topeka
Mary Neubauer	ASSOC Press	Topeka
Bill Dean	NKF	O.P. Ks.
Mary Sprinks	Health Benefits Adm	LSOB Rm 553-S

TESTIMONY BEFORE HOUSE PUBLIC HEALTH & WELFARE COMMITTEE

By: Jeffrey O. Ellis

Governor's Commission on Health Care

February 11, 1991

Chairman and members of the Committee.

I appreciate the opportunity to review with the Committee the report and recommendations on the Kansas Health Care System prepared by the Governor's Commission on Health Care, November 28, 1990. I am Jeff Ellis, an attorney in the Kansas City area, and served as Task Force Chairman of the Policy Development Subcommittee of the Commission. The Commission was chaired by James O. Foster of Wichita. Other presenters today will be Barbara Gibson who chaired the Commission's subcommittee to review prior Commission reports and G. Wayne Johnston who chaired the subcommittee on financing and insurance.

Before discussing with you the specific recommendations of the Task Force on policy development, your Chairperson asked me to make a presentation which I have prepared for employers concerning the directions in health care and challenges for the 1990's. Representative Sader heard my presentation to the Johnson County United Community Services Board about a month ago. I believe that it will serve as useful background material to explain the Commission's recommendations.

What are the challenges in health care for the 1990's? Regardless of one's perspective, the overriding challenge is dealing with the issues of health care cost and value. All categories of payors - individual consumers, employers as purchasers of health benefits, government as funders of care for the poor, and to the elderly, and taxpayers footing those public expenses - share concern about rising costs and the question of value.

Our national health care expenditures more than doubled in the decade of the 80's. This year, they will pass the $600 billion mark. The figure I saw at the end of 1990 was $689 billion.

Exhibit
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All three major components of personal health care expenditures - physician services, hospital services, and prescription drugs - have been climbing at a rate higher than all other items in the consumer price index.

Health care is approaching 12% of our gross national product. That is tops among the leading industrialized nations.

By a per capita measure, we also rank first. We exceed our neighbor Canada by 38%, and our major competitor Japan, by 124%.

One might say, isn't that the price we pay for a health care system that is the envy of the world?

Is it?

The United States lags behind most other industrialized nations in at least three key measures of health status. We continue to rank near the bottom along side the United Kingdom by the measure of life expectancy. We are dead last by the measure of infant mortality rates. 99% of all U.S. births occur in hospitals, and 98% are attended by physicians, but only 75% of all U.S. expectant mothers start receiving prenatal care in their first trimester. 11% receive none at all, or none before the third trimester.

Moreover, only about two-thirds of our nation's children who survive infancy are current in their immunizations. This compares with 97% of all children in the Netherlands, which spends half as much on health care per capita.

Not only is per capita spending high, but the rate of increase has been alarmingly high. We know the factors driving our health care costs.

One villian is general inflation. There is no escaping its grip. It affects every producer of goods and all providers of services. For 1989, the rate of general inflation was 5.2%.

A second factor is new technology. In most other industries, new technologies proliferate because they yield cost savings or improve quality or do both. In health care, however, that is not necessarily so.

Just consider the CT Scanner and now the MRI. On a per capita basis, the United States already has nearly four times the availability of MRI, compared to West Germany, and nearly eight times the availability as Canada.

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A third generally accepted cost-pushing factor is increased utilization and intensity. Consider our rapidly aging population. The elderly, our fastest growing age group, use hospital care more than five times the rate of all other age groups combined but we cannot arrest aging. Increased utilization and intensity are driven by other factors. Some should be susceptible to management and avoidable through effective prevention and education. The AIDS epidemic is one example. Then add the diseases caused by life style habits, such as cigarette smoking and other substance abuses that affect not just the abuser. Nearly 5% of all deaths in this nation are from alcohol-related causes. An estimated 13% of all homeless women on any given day are pregnant. Many are addicted to crack and birthing babies whose prenatal care runs into scores of thousands of dollars. Care for 100,000 crack babies born every year in this country is costing $3 billion annually.

So where is it all leading us? Many employers are reacting much like the celebrated T.V. commentator in the award-winning movie "Network" whose urged his viewers to fling open their windows and yell, "I'm mad as hell and I won't take it any longer!" Employers are shouting about health care costs, and government, insurers and others are listening.

Health benefit costs took off in the late 1980's, increasing by more than 50% in the last half of the decade. Ironically, the health care system as it exists in the United States was created by employers. About 45 years ago, our nation embarked on a clear but undeclared national policy. We set out to make financial access to health care and implicit right in the brave, new post-war world. Business willingly took the lead in reducing financial barriers to care. The major means was employer-paid health benefits. The federal government supported and subsidized the trend by treating health benefits as tax-free compensation to workers, and a tax deductible cost of doing business for business. These tax breaks to employers and employees totaled $32 billion last year alone. Ultimately, of course, the consumer paid. Pass-through by price increases of the products sold was easier when direct competitors had roughly the same cost burdens.

Organized labor drove the trend by negotiating for broader benefits, maintenance of benefits, and employer-paid coverage for dependents. Business generally accepted it as good for business.

At the end of World War II, less than 25% of our population had health coverage, and most were limited to in-patient care only. By 1960, the figure had nearly tripled and included employees of the federal, state and local governments, as well. Benefits expanded to include physicians' services for in-patients

and out-patients. The unemployed, poor and elderly were tucked into the trend by enactment of Medicare and Medicaid.

By the early 1970's, about 90% of our population was covered by privately or publicly funded health benefits. In 1990, nearly 30% of all Americans are without continuous, uninterrupted coverage and 15% lack any coverage at any time.

What happened?

For one thing, many goods and services of American businesses had become international commodities in a highly competitive economy in a shrinking world. Cost control has become a necessity for survival of American businesses in world competition. Employee health benefits became one of the last uncontrolled costs. And then, more recently, the Financial Accounting Standards Board initiated a requirement that employers must recognize our enormous commitments to health benefits for our retirees as a liability on our balance sheet. Furthermore, we must begin to fund this liability with real dollars.

Hundreds of billions of dollars are involved. In 1950, there were about 17 active U.S. workers for every retiree. Some demographer's estimate that by 1992, that ratio will have dropped to 3 to 1.

Our private sector pays for nearly 60% of our national health care bill, according to figures from the Health Care Financing Administration.

Chrysler Corporation reports its health care costs, including costs its suppliers pass along in the prices of their parts and services, average about $700 per car. More recently, General Motors has estimated that amount to be about $1,200 per car. As a comparison, Japanese producers average only $280 per car and a German firm only about $380.

Employers have taken several courses of action to contain their health benefit expenditures. One is cost shifting by having employees pay more for health care.

According to an annual Foster Higgins survey of large employers offering indemnity or self-insured plans, those requiring employee contributions to premiums for individual coverage and for dependent coverage increased last year from 39 to 45%, and from 69 to 75%, respectively. A majority, 56%, said they intended to increase their employees' contributions again by the end of this year.

Cost shifting of premiums, however, has resulted in little more than holding the line at the risk of decreasing employee morale and participation. And, it does nothing to moderate total cost growth.

Costs also are being shifted to employees by increasing co-insurance and deductibles. A study by the Rand Corporation found, among other things, a direct correlation between cost sharing by consumers and lower utilization.

Another approach to cost shifting focuses on post-retirement health benefits. A recent survey by Business and Health found that 41% of employers already have increased cost shifting onto current retirees, and 91% say they already have eliminated health benefits for future retirees, or plan to do so.

These actions by employers are influencing employee relations. A recent survey asked 50 labor leaders to identify the most important issue in collective bargaining. What do you think was their answer? Wage rates was not the most important issue, nor was job security. Nor was improved pensions. For the labor leaders, maintenance of health benefits was the issue most frequently cited. In addition, health benefits were a major issue in 78% of all strikes mediated by the federal government last year, up from 18% four years ago.

Many employers also have been focusing actions in areas they believe are primarily responsible for health care cost escalation. For a system they feel is out of control, they are seeking ways to manage their health care costs by influencing the management of health care itself.

A recent survey of large employers by the Washington Business Group on Health found the majority blamed providers for causing cost escalation.

Physicians' services account for only about 20% of all personal health care spending. However, employers recognize that physicians control the majority of all expenditures by virtue of their professional decisions. For most part, chief executives opposed direct price controls on providers, a large majority supported utilization reviews and protocols to influence providers' decisions.

This mind-set is changing the practice environment for physicians. They are being subjected to requirements of prior authorization, second opinions, utilization review, and other controls imposed by or on behalf of large payors. Many insurers are developing similar systems of their own.

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Polls indicate that the majority of Americans, 60% by one recent national survey, still believe adequate and affordable health care is a basic right. 89% said fundamental changes were needed in the current system, and 67% favored universal health insurance funded by the government.

We know, however, that government isn't really a source of funding. It is only a conduit for payment. The burning question remains: who pays?

The majority of Americans, 55% in a recent poll, said they would pay more taxes to assure affordable care for everyone. 75% of them said they would be willing to pay no more than about another $4.00 per month.

At the federal level, political observers generally agree any form of universal health coverage is highly unlikely until the federal deficit is no longer an issue, or until some consensus develops on a private sector solution. That private sector solution keeps moving toward managed care.

The Governor's Commission on health care, recognizing the magnitude of the health care crisis in this country, has proposed a number of recommendations which would create an environment for private sector solution and focus governmental action and involvement in what would hopefully be a coordinated, comprehensive and cost effective solution to the problems.

The task force which I chaired was concerned that Kansas and the nation lack any stated health care policy. Our subcomittee was, therefore, tasked with the responsibility for recommending a mechanism to develop such a policy for the State of Kansas and to continue the evolution of that policy on an ongoing basis.

Kansas currently approaches health care policy piecemeal through various well-meaning but uncoordinated programs implemented through several governmental agencies. The "squeeky wheel" syndrome often determines policy priorities. The members of the Governor's Commission on Health Care believe that the provision of health care for all Kansans citizens can be enhanced measurably by the creation of a central policy formulation mechanism to serve as the focal point of public and private debate regarding health care concerns.

The balancing the interests of the public and private sectors is a complex process. In the public sector, several governmental agencies are charged with segments of health care policy formulation and implementation. Currently, the administrative and legislative branches of government must

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confront health care issues. The Kansas Department of Social and Rehabilitation Services, the Kansas Department on Aging, the Kansas Department of Health and Environment, and the Kansas Insurance Department all confront health care issues daily.

The creation of a new joint legislative committee on health care decisions was a step in the right direction to "improve the ability of the legislature to make informed decisions, to allocate resources according to priorities developed by the legislature itself, and to better respond to initiatives proposed by state agencies and interest groups". The Joint Committee will hopefully serve as a "legislative focal point for public input and coordination of policy on issues that cut across committee jurisdiction".

In the private sector, health care providers seek to provide quality health care while payors of health care costs seek to moderate costs and find affordable products which will allow access to health care for all Kansas citizens. The citizens of Kansas seek the availability of quality health care at affordable prices primarily through individual health insurance policies, private payments, employer insurance programs or governmental health care programs.

The need, however, for available and affordable health care increases. The Commission on Health Care proposes that there be established a durable decision-making process that would provide the forum for the short and long term health planning and policy formulation; a process that will balance public and private sector concerns.

I might point out that each task force of the Commission independently and separately recommended a centralized policy formulation mechanism. The structure which is described at pages 14 through 18 of the Commission's report was the consensus of the entire Commission as the best mechanism to accomplish the purpose.

The Commission recommends that health policy formulation can best be achieved through the establishment of a health policy office operating in conjunction with a health authority within the executive branch of government. The purpose of the Kansas Health Authority would be to: (1) consult with and be advisor to the Governor, the Legislature and the Director of the Kansas Health Office; (2) to encourage state health policy adoption; (3) to make recommendations to other state agencies and political subdivisions of the state for the coordination of their activities relating to the provision of basic health care to all Kansans and the promotion of disease prevention in health care education throughout the state; (4) to develop a state health plan and review legislation to implement such a plan; (5) to

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recommend rules and regulations for the implementation of a state health plan; (6) to appoint citizens' advisory committees to serve as a forum for receiving the advice of Kansans, health care professionals, community leaders, insurers, educators, business, industry, locally elected officials and others wanting to explore issues and achieve consensus on health care problems in Kansas.

The Kansas Health Authority and its operational arm, the health policy office, would be quasi-governmental in nature. It is recommended that there be established within the executive branch a Kansas health policy office administered under the direction and supervision of the Director of the Kansas Health Policy Office. That director would be appointed by the Governor subject to confirmation by the Senate. The director would serve for a set term of four years. All budgeting, purchasing and related management functions of the Kansas Health Office would be administered under the direction and supervision of the director. He or she would also hire employees for the office.

Our Commission also recommended that there be established, within and as a part of the Kansas Health Policy Office, the Kansas Health Authority to serve as the policy making body. The authority would be composed of 21 members representing a balance of interest groups and citizens.

The chairperson would be selected by and serve at the pleasure of the Governor. One member would be appointed by the President of the Senate, and one member would be chosen from the membership of the House of Representatives by the Speaker. Private citizens representing consumers of health care would be chosen by the Governor, two from each of the soon-to-be four congressional districts within the state. These citizens should not be payors or providers of health care. One employer representative would be chosen by the Governor from recommendations by the Kansas Chamber of Commerce and Industry and one employee representative would be chosen by the Governor from recommendations by the Kansas Labor Counsel. There would be three representatives of payor groups, one representing domestic life insurance companies, one representing Blue Cross/Blue Shield of Kansas, and one representing the Kansas HMO Association. The final five representatives would be health care providers, one representing the Kansas Hospital Association, one representing the Kansas Medical Society, one representing the Kansas State Nursing Association, and two providers chosen at large from the list of provider groups as defined by the authority from Medicaid approved provider list.

The Commission recommends that the appointees to the Kansas Health Authority be chosen on as non-partisan basis as possible and serve for a fixed, four-year terms, which would be staggered

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to assure continuity and experience among members of the Authority. Moreover, the Governor should assure that in making appointments that at least five of the 21 representatives on the Authority should be residents of rural counties of less than 10,000.

Governmental agencies which are deemed to have regulatory impact on the implementation of health care policy should be represented on the Authority ex-officio without vote. Certainly, the Department of Social and Rehabilitation Services, the Department of Health and Environment., the Department on Aging, and the Kansas Insurance Department should be represented. It is also recommended that the University of Kansas Medical Center be represented ex officio and consideration be given to the Department of Human Resources and the Department of Administration for ex officio membership.

The Governor's Commission strongly believes that the only realistic chance of developing a state health policy is to do it through the quasi-governmental - quasi-independent authority like we described in the report. There is no particular pride of authorship in the design we proposed. The important notion here is that such an authority be established which would allow for debate of public policy issues regarding health care among a balance of participants who have direct interest and involvement in health care matters. Currently, coordination among the agencies of the executive branch of government is needed and advisable. Certainly, the Legislature serves as a forum for the debate of public policy issues. We believe, however, the Legislature, by its nature, has difficulty determining the comprehensive health care policy direction. That direction can and more properly should be a function of the executive branch.

Several legislative committees, interim committees, commissions, private individuals and governmental agencies have suggested a multitude of recommendations regarding the delivery of health care for Kansans. The Governor's Commission on Health Care attempts to bring those recommendations together and to prioritize them. As the result of that process, we strongly urge your favorable consideration of the creation of an institutionalized mechanism to establish health policy for the State of Kansas.

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