Approved 3-5-91
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./~~p.m.~~XX on February 27, 1991 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Senator Doug Walker
Senator Wint Winter
Orville L. Voth, Silver Haried Legislature
Donald A. Wilson, President, Kansas Hospital Association
Jerry Slaughter, Kansas Medical Society
William R. Roy, M.D.,J.D.
Katherine Pyle, Capital City Task Force, AARP
Harold Riehm, Kansas Asosciation of Osteopathic Medicine
Judith Arentson, Women Retired, Lawrence
Kelly Kultala, National Organization for Women
Charles Dodson, Kansas Association of Public Employees
Myrna Stringer, League of Women Voters of Kansas
Ralph Wright, Pittsburg, Retired

Chairman Ehrlich called the meeting to order at 10:00 a.m. asking for approval or correction to the minutes of February 19, 20 and 21, 1991. Senator Langworthy made the motion to accept the minutes as presented, seconded by Senator Hayden. Motion carried.

Hearing on:

SB 205 - An act establishing the Kansas health care commission and providing for the powers, duties and functions thereof; providing comprehensive, statewide health insurance coverage for all residents of the state; providing for the financing thereof.

Senator Walker, principal sponsor of SB 205, submitted written testimony and spoke in support of the bill. SB 205 is based on the Canadian health care system and provides for access to basic, primary health care services for every Kansan. Senator Walker stated that SB 205 establishes a 21-member Health Care Commission governed by a Board of Directors, which would manage health care in Kansas. Funding for the plan would require several federal waivers to allow the state to use Title 19 funds. Under this plan, all Medicaid and Medicare clients would be indistinguishable from other participants. He also stated additional funding would come from an income tax surcharge of from 1% to 5%, based on individual income. A 10% tax on alcohol and tobacco products, a 2% tax on interest and dividend income in excess of $1,000, and an 8% payroll tax on employers would help fund the plan. Senator Walker explained this was the first plan to be presented to the legislature that would face most of the problems in health care today. (Attachment 1) Senator Hayden questioned about rural and urban representation on the policy making board.

Senator Wint Winter, co-sponsor of the bill, appeared in support of SB 205 stating his reason to introduce the bill was because the health care system is fundamentally broken. Senator Winter expressed concern regarding the high number of people not covered by health insurance, the high infant mortality rate, high number of people denied medical coverage and the closing of nursing homes that fail to provide health care. He also pointed out the high cost of medical expenditures by SRS, and SB 205 being the start in reforming the cost of health care in this state.

Orville L. Voth, Kansas Silver Haired Legislature, submitted written testimony and appeared in support of SB 205 stating affordable health care is essential for everyone. (Attachment 2)

Donald A. Wilson, Kansas Hospital Association, stated his association recognizes the need for affordable health care for all Kansans, and SB 205 is just the beginning in solving the problem. He recommended more discussion and debate take place and the bill be held over for further study. Nine goals that the new health strategy plan should meet were also explained. (Attachment 3)

Jerry Slaughter, Kansas Medical Society, presented written testimony and appeared before the committee stating he applauds the willingness of the legislature to look at the health insurance system on a broad scale, but feels the bill should be referred to the Joint Committee on Health Care Decisions for the 1990's for further study. (Attachment 4)

William R. Roy, M.D., J.D., presented written testimony and appeared in support of SB 205 stating the need exists to provide affordable health care services for everyone. He also stated there are deficiencies in the bill as written. They include an unnecessary two tier system, something less than a full time commissioner, coinsurance and maximum pay ceilings that are too high, and the call for a payroll tax. He stated further that the system should be primarily financed by health insurance premiums paid by employers based on wages and salaries. Because over one-half of the states are considering bills similar to this one, there is hope for wrenching health care jurisdiction and accompanying money away from the federal government and getting it into state hands. Capitation has already been established for Medicare, and Medicaid monies to the states already have established formulae. He summaried his testimony by stating a perfected Walker-Winter bill is the only hope for expanding access, containing costs, keeping a private health care system and avoiding overt rationing. (Attachment 5) After committee discussion, Dr. Roy stated the bill deserves an interim study committee.

Other proponents on SB 205 and submitting written testimony were: Katherine Pyle, AARP, stated the advantages of the bill for the elderly, (Attachment 6); Harold Riehm, Kansas Association of Osteopathic Medicine, recommended an interim study and a series of town meetings throughout Kansas, (Attachment 7); Judith Arentson, Women Retired of Lawrence, expressed concern for those without health insurance, (Attachment 8); Kelly Kultala, National Organization for Women, with a suggested amendment: on page 4, lines 1 and 22, to include "birth control upon request for all men and women in the state of Kansas", (Attachment 9); Charles Dodson, KAPE, stated the bill has many unanswered questions, however, the scope of the changes promoted by this bill are in line with what will be necessary to grasp a solution, (Attachment 10); Myrna Stringer, League of Women Voters of Kansas, supports the concept of the bill, specifically under Section 4 (a) 6, and that the state should take the responsibility for devising a plan to care for the medically indigent in Kansas, and for providing funding and program guidelines for health care and health education, (Atachment 11); Ralph Wright, Pittsburg, expressed his concern of high cost of health insurance for the elderly and suggested recommendations, (Attachment 12).

Written testimony was submitted by Keith R. Landis, Christian Science Committee on Publication for Kansas, with suggested amendment that: "The plan shall include benefits comparable to medical benefits for those who rely upon spiritual means through prayer alone in accordance with a recognized religious method of healing permitted under the laws of this state". (Attachment 13) Also submitting written testimony was Kevin Siek, Kansas Commission on Disability Concerns, who stated his support of SB 205 regardless of income or medical condition. (Attachment 14) Charles Konigsberg, Jr., Director of Health, Department of Health and Environment, submitted written testimony and stated four areas of concern: (1) definition of "comprehensive, necessary health care services for all residents"; (2) how the bill will impede, not enhance access to care; (3) capacity of the system to absorb an additional 375,000 patients; and (4) access problems for rural Kansans. KDHE applauds the effort represented by this bill to cope with the two major issues of lack of access and skyrocketing health care costs. (Attachment 15)

The meeting was adjourned at 11:05 a.m. with opponents of the bill to be heard February 28, 1991.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-27-91

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Geraldine Morgan	Holton	Senior Citizens
Mary Doyle	Holton	" "
Ann Stacer	Topeka	KHA
Don Wilson		KHA
Melissa Hunsicker		KHA
Jim Schwartz		KECH
John Kosek		Bc/Bs
Opal Pettengill		
Betty E. Scott		aaa
Rita Jenkins		Jo Co Senior Citizen
James R Scott		Jo Co Senior Citizen
Dorothy Wardin		LWV, KCOA
Judith Arentson		Older Women's League
Linda Lubensky		KS Home Care Assoc
Charles Dodson		KAPE
Kyle Hoy Sr.		Topeka (no agency)
Priscilla Foster		Silver Haired Legislature
Nancy Zogleman		BC/BS of KS
Bill Sneed	Topeka	Smokeless Tob Council

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-27-91

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Marilyn Bradt	Lawrence	KUNH
Petey Cerf	"	
Marge Harder	"	
Maryan Harder	Moundridge	
Shannon Bruggen	K.C.	Student - KU
Dorothy Landeyo		Agency on Ageing Marysville, Ks
Nancy Rudolph, Marysville		Marshall Co. Agency on Aging
Alice Zaeske	Marysville	
Merlin Zaeske	Marysville	Marshall Co SRS
Catherine Utecht	Marysville	Marshall co. Agency on Ageing
Gerald Beightel	Halton	Jackson Co. SRS
Dorothy Beightel	Halton	
Evelyn L. Hecker	Tonganoxie Ks	Jackson County Senior Citizens Halton KS
Ralph Wright	Pittsburg	
Tom Bell	Topeka	KUH
Mary Sprigg	Topeka	Ks. St. Emp Health Care Commission
Tom Esseman	Topeka	KS. Insurance Dept.
Cassie Lawson		KONE
Harry Speer		Humana Prime Health

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE Feb. 27-91

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Kelly Kultala	NOW
George Goebel - Topeka	AARP SLC CCTF Chr.
Tim Nedeau Hays	
Katie Pyle	AARP CCTF / SHL
FRANCES KASTNER	Ks Physical Therapy Assn
ALAN ANDERSON	TOBACCO INSTITUTE
Lou Jane Schmidt	HIAA
Myrna Stringer	League of Women Voters of Ks
Charles Koenigsberg	KDHE
Steve McDowell	KDHE
Sherr Holliday	Budget Division

STATE OF KANSAS

DOUG WALKER
SENATOR, 12TH DISTRICT
MIAMI, BOURBON, LINN,
ANDERSON, ALLEN AND
NEOSHO COUNTIES
212 FIRST
OSAWATOMIE, KANSAS 66064
(913) 755-4192 (HOME)
(913) 296-7380 (STATE CAPITOL)

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNM.
MEMBER: CONFIRMATIONS
EDUCATION
ENERGY AND NATURAL RESOURCES
FEDERAL AND STATE AFFAIRS
PUBLIC HEALTH AND WELFARE

TESTIMONY FAVORING PASSAGE OF SB 205

I wish I could tell you today that SB 205 is a simple little bill which will solve our health care crisis. I do, in fact, believe that SB 205 will go a long way in solving our health care problems -- but it is anything but simple.

This Plan is based on the Canadian system and provides for access to basic, primary health care services for every Kansan. Every resident of the State of Kansas will be covered by a Health Care Plan which excludes no one and, in effect, makes the state a single group for insurance purposes.

SB 205 establishes a 21-member Health Care Commission, governed by a Board of Directors, which would manage health care in Kansas. Section 4 spells out the specific functions of the Commission. This Commission would manage the Kansas Health Care trust fund which would be the single source of payment for all covered health care services in Kansas. (p.2)

The Commission would negotiate with providers on reimbursement rates. It will establish budget and policy guidelines, establish fee schedules, and monitor the Plan and make any necessary changes in coverage.

The Commission will also appoint an 11-member Health Services Subcommittee to determine appropriate levels of coverage and services to be provided under a two-tiered coverage plan.

Senate P H &W
Attachment #1
2-27-91

This section of the Plan incorporates part of the philosophy of the Oregon Plan.

Part 1 coverage is to include basic, preventative and primary health care services. Monies spent under Part 1 coverage will cover services, prioritized to provide the best overall cost-effective health care system to the greatest number of individuals. At this time, it is impossible to be specific about what Part 1 coverage will actually cover, but it would be my intent to reallocate resources to front end services, such as prenatal care, prevention of early childhood disease, and early detection and treatment of diseases.

For every service covered under Part 1 coverage, a non-insurable copayment would be required. This copayment would be based on the individual's income and is graphed on page 5 of the bill. The reason for the copayment is to put patients back in touch with the cost of their care, and allow them to make health care decisions based on the knowledge that their care will cost them something. This, in itself, should help control over utilization and abuse. The copayments are on a sliding scale based on income and there are limits on out of pocket expenses.

Part 2 coverage would be optional, supplemental coverage and could be purchased from the Plan under a separate system, but more likely would be purchased from private insurance companies and would cover procedures and treatments not covered in Part 1. Again, Part 2 coverage would be determined by the Subcommittee but I would expect such procedures as transplants and other exotic treatments would be addressed under Part 2 coverage.

There is also a 12-month waiting period for Part 2 coverage if obtained from the Plan.

Hospitals will negotiate with the Plan an annual budget to cover anticipated services for the next year based on past performance and projected changes in price factors and service levels.

Professional organizations of other providers will negotiate for services and all providers will be reimbursed at the negotiated rate.

Funding for the Plan will require several federal waivers to allow the state to use Title 19 funds. Under this Plan, all Medicaid and Medicare clients would be indistinguishable from other participants.

Additional funding for the Plan comes from an income tax surcharge of from 1% to 5%, again based on individual income. A 10% tax on alcohol and tobacco products, a 2% tax on interest and dividend income in excess of $1,000, and an 8% payroll tax on employers will also help fund the Plan. The 8% employer payroll tax is in line with the amount employers that are currently providing health insurance benefits pay and, in many cases, it will be less. By having a payroll tax, employers such as WalMart and McDonalds who hire employees just enough hours to avoid providing benefits will be required to pay. Whether the merchant employs a person for one hour or for 60 hours, he must still pay 8% of that person's salary.

This is the first plan presented to the Legislature in which most of the problems facing health care today are addressed. It

is comprehensive and will fundamentally alter the way we provide health care in this state.

The introduction of this bill serves several useful purposes. First of all, if adopted, it would solve many of the problems we face today. Second, it puts providers on notice that we think the current system is definitely broken and must have a major overhaul to fix it. I believe this Plan is that major overhaul. It is also a message to the federal government. It is my understanding that 35 states have introduced major health care reform legislation in the past 2 years. Legislation like this tells the federal government to give us the waivers and flexibility to allow us to solve the problem or get its act together, address it and solve it on the national level.

I truly believe when we eventually get around to reforming the present system, it will look very much like the system proposed in SB 205.

SUMNER COUNTY FAMILY CARE CENTER
Joel T. Weigand, M.D.
Larry R. Anderson, M.D.
1323 North A.
Wellington, Kansas 67152
316-326-3301

February 26, 1991

RE: Senate Bill 205

With 500,000 Kansas citizens unable to purchase health care insurance, and with traditional health insurance family premiums of $500 per month, I ask you to consider with me and accept the following premises:

I. The health care delivery system of the United States of America is badly out of balance and major restructuring of health care delivery is mandatory.

II. Access to a basic core of health care services is the right of every individual.

III. Health care for the poor should be purchased by funds generated from income tax revenue.

IV. Medicare health insurance will continue to be funded through social security contributions, and senior citizens with financial resources will be expected to pay more of their future health care costs.

V. The majority of the remaining individuals should be covered through employer-purchased or self-purchased health insurance programs.
   A. A basic core of health care services will be the minimum coverage available.
   B. Employers or employees wishing higher levels of coverage will be expected to provide additional premium dollars.
   C. Insurance programs should be structured so as to encourage cost-efficient decisions by health care consumers and providers
   D. Insurance policies should be available for those individuals wishing to purchase coverage for any foreseeable event.

VI. Malpractice tort reform legislation must be expanded to protect health care providers when services that might be beneficial for a patient are not provided because the services are not covered by insurance (as in the Oregon legislative actions).

Senate Bill 205 is an aggressive, innovative approach to necessary health care insurance reform, and I encourage your strong consideration and support of the concepts contained in this bill.

Sincerely yours,

Larry Anderson MD

Larry R. Anderson, M.D.

LRA/cm

1-5

HEALTH CARE CRISIS

Our present form of health care/insurance in Kansas is KILLING US and right now it looks like I might be next! In support of the bill, "Kansas Health Care Act", please consider the following article written by me and printed in the Hutchinson News Western Front this month.

EVERYTHING MUST BE DONE TO INSURE THAT WHOEVER GETS THE WELL DOLLARS OVER THE YEARS, MUST BE THE ONE RESPONSIBLE FOR THE PERSON WHEN HE GETS SICK!

Insurance companies have failed to do this, so a State-wide plan is the only fair way to get everyone into one large pool that will spread risk and still provide care for all. It would also have the leverage needed to help control costs.

If I can help in any way, contact me: Marlin M. McFarland, RR 2, Box 77A, Sterling, KS 67579 316-278-2754

Insurance firms unfair to sick people

Sure! Sure! If I were an insurance agent in Kansas, I would be delighted, too, with the job done by the Kansas insurance commissioner. His job protects profits for the insurance companies doing business in Kansas. He allows them to slide out from under their contracted risk if losses start to affect their bottom lines.

Take a look at Kansas health insurance. Companies are allowed to do business in the state, then sell out to satellite companies if profits are not good. Those companies fold, leaving all the sick uninsurable.

Another method used by the companies to insure only well people is the tactic of isolating the insured in small pools. If someone gets sick in the pool, the insurance company can raise the rate of that small pool to cover costs (including their profit). The higher rates encourage the healthy to drop out, and then rates escalate until the sick cannot pay. Then when they have to drop out, it looks as if the sick persons withdrew by their own free choice.

In the wake of both of these practices, a stream of people is excluded from buying insurance either because of cost or, worse yet, because they now are uninsurable due to an existing health condition.

The insurance companies want to insure only well people, take the profit, and dump the sick if they start to become an expense. Those who are dumped, futilely spend their life savings trying to pay for their own health care, but actually use up only the future security of those they leave behind. Their effort soon proves impossible because of jacked-up prices required by doctors and hospitals trying to recover costs incurred from the growing number of those not paying in full. Those getting services at a reduced rate include: the growing number of those uninsured, those who pay for services through Medicare/Medicaid, and also certain Blue Cross policyholders. All these groups require the health care providers to accept less reimbursement than the billed amount. Those who pay the full amount are the individuals without insurance or the smaller insurance companies.

In my case, after paying for health insurance for 20 some years, my insurance company dropped everyone in the state. Trouble is, now I have cancer, and no company will take me. All my "well dollars" paid in the past went to the insurance company instead of into a "true" pool for the sick. In effect, I helped them turn profits while they failed to provide the very thing that I bought insurance for — coverage if or when I got sick. I didn't need the coverage while I was well; that money was intended for the sick. No insurance company should ever be allowed to drop someone, once he or she gets sick, unless that person is able to find coverage. The state should implement a method of making sure that Kansans are getting true health coverage and not an insurance company's money-making scheme!

Sure, I notified the insurance commissioner, but he said that it was all legal. Some "watchdog"! He led me to believe, however, that it rarely happened in Kansas. I have since found that it happens more often than was indicated. In fact, the number of those who are being canceled or run off through small-group price jumping, is rapidly growing in Kansas. This "head-in-the-sand" tactic from the commissioner's office is not what the people of Kansas need.

Our "watchdog" needs to get after the job at hand if he is ever going to shake his "insurance company pet" image. He needs to direct the insurance companies away from their favorite small-group pool concept of insurance. Those small groups are a good deal only until there is one illness, and then the premiums jump sky-high and those who are healthy jump off, leaving the sick to cover themselves.

The health care problem in Kansas is growing, and it won't go away soon. Compared with other states, we are behind in trying to do something about the situation. Many states have a high-risk pool, which requires all insurance companies (that do business in the state) to take on a few of the customers dropped when a company quits or goes out of business. But such a pool would be worthless if the insurance companies could just drop their sick people into it while keeping those who are healthy.

Oregon is experimenting with a plan to cover everyone in the state, a plan patterned somewhat after the successful Canadian health care system. In 1965, Canada and the U.S. were spending about the same percentage — 6 percent — of their gross national products on health care. Since then, with the U.S. retaining the private insurance route, we spend over 11 percent of our GNP on care, compared to Canada's 8 percent.

Canada'a people-oriented system is costing each person only $50 per month, and everyone is covered. All doctors' visits and medicine are included. A vast majority of people like the system and the care given. The facts show that Canada is beating the U.S. in results at both ends of the life span, with fewer infant deaths and a longer life expectancy.

Of all the industrialized nations, only the U.S. and South Africa fail to provide access to health care for all their citizens. Yet we rank 12th in life expectancy and 21st in stopping infant deaths.

According to Dr. Jane Fulton, a professor of health policy at the University of Ottawa, "In the next decade, if you don't have a national health system, the insurance companies will continue to selectively-deinsure. No matter how many premiums you've paid, you'll never know if you'll be next!"

MARLIN McFARLAND
Sterling

H-6

Tel No.
913 842-6513

Older Women's League
Kaw Valley Chapter
1500 El Dorado Dr.
Lawrence, KS 66047

Sen. Doug Walker
Public Health & Welfare Comm.
State Capitol

Feb. 23, 1991

Dear Sen. Walker —

I'm responding to your letter of Feb 20 re Hearings on SB 205 this Wed., Feb. 27 -- Ironically, AARP has scheduled an all-day Health Concerns seminar for that very day, and our O.W.L. Chap. has committed to participate.

Therefore, I am putting in writing some of our current thoughts and concerns re SB 205, and I would ask you, please, to share them, on our behalf, with your Public Health and Welfare Committee.

Firstly, we appreciate very much the initiative and leadership you and our Sen. Wint Winter have shown in bringing before our State a program of comprehensive, Statewide health insurance coverage for all KS residents. The need is dire, not only among the working poor without coverage, but for all those Kansans who see their premiums rising, more and more gaps appearing, more and more out-of-pocket expenditures -- and those whose insurance has been dropped when they need it most -- and those, because of pre-conditions -- can't get health insurance at all! ← (Irony of ironies!!)

Then, too, the tremendous reams of red tape that both providers and recipients are strangled in, the exorbitant administrative costs -- that could be beautifully streamlined under a single-payor, not-for profit system eliminating duplications, the depersonalization of our dr.-patient relationship brought about by the

1-7

Tel. No.
[illegible]-842-6513

Older Women's League
Kaw Valley Chapter
1500 El Dorado Dr.
Lawrence, KS 66047

p. 2 — Re S.B 205
KS Health Care Act

edicts from insurance companies! -- blatant non-profes. entry into often life-and-death patient-dr. diagnosis and recommendation of needs -- all of these, as well as the present suffering and impoverishment and fears that such scenarios conjure up in us all are what Kansans have been waiting -- and working toward.

Our concern is that we are not certain you have been bold enough. We worry about the "second tier" -- and whether you are indeed establishing a system for the poor and one for the rich... We compare the services covered, p.8, lines 7-17, with the Florida Health Care bill equivalent Sec. 13 (p.10-11), which I enclose, and which seems so much more reassuring... -- and we ask why have you been so meek in setting services forth, left so much for a "subcomm.tee" which may/may not include these basics.

Also, in what is NOT covered in your SB 205 bill, p. 8, l. 26, "Basic care rendered in a nursing home," as compared to YES-COVERED! under Florida's plan, p. 10. (j). -- True, we want to provide alternative, home-based options, a whole continuum of incremental services, hopefully, YES-PROVIDED (as Florida's pt(f) does -- but there are people who do need p 10 "basic nursing home care," some, hopefully, only temporarily,

1-8

p.3 - Kaw Valley O.W.L. - re SB 205

others, without alternatives. Where are they to look for financial succor?

We also wonder if the "co-paymt." for prescription medicine, p. 8, line 9, does not, again add opportunities for complications and bill-bloating!! -- compared to Florida's p.13, single-collection cost-determination per resident and per family for their all-services-included provision. (I also enclose a summary of their financial calculations as to savings under their system, and the breadth of bold revision of their system they have set forth!)

We challenge you and your Comm.Hee to set forth universal, comprehensive single-tiered coverage that makes us all feel secure. Enumerate, as p.10 & 11 of Florida's Health bill has done those health services included. -- As the insurance companies and pharmaceuticals have already declared their opposition, do spell out clearly for the rest of us what is included so you can have the support of all the rest of us!!

Respectfully submitted,

Hilda Enoch, Pres. (842-6513)
Kaw Valley Chap. Older Women's League

copy - Sen. Wint Winter

Enclosures

P.S. - Sen. Walker, I called on Friday, Feb. 22 -- to ask if you'd help us by sending a resource person to our O.W.L. sponsored community-wide Forum on Health Care Concerns, Thurs. Mar. 14, 2 p.m. at our Public Library. Would you please call me on this? (I'm also in touch with Sen. Winter about this need... 1-9

States must initiate national health care

By GEORGE A. SILVER
L.A. Times-Washington Post Service

If we want a national health program — and it is clear from polls over the years that most Americans do — we're going about it the wrong way. It is not only Congress to which demands should be addressed, but state legislatures as well. Those who call for a national health program have for nearly a century stubbornly concentrated on getting Congress to initiate it. In doing so, they have ignored 200 years of American history. You'd think they would have caught on by now to the futility of this approach.

Agitation for a national health program began in 1907, and bills have been introduced nearly every year since 1916. Not one of them has ever gotten out of committee. One administration after another has recommended national health insurance legislation, and Congress has received dozens of reports proposing such action over the years. The latest such episode is the report issued by the Pepper Committee, which was pronounced "dead on arrival" by members of the committee itself.

It follows the Report of the National Leadership Commission on Health Care this past year and will join it in the collection of forgotten proposals gathering dust on library shelves.

On the heels of this congressional report proposing a national health program, President Bush asked the secretary of health and human services, Louis Sullivan, to undertake another "study" and come up with a recommendation for a national health program. Dr. Sullivan will probably devote a year or so and several million dollars to producing another Congress-focused proposal to join in the archives the Wagner-Murray-Dingell bills, the Truman Report, the Eisenhower administration's "Goals for Americans," the Johnson administration's "Health Manpower Report," Walter Reuther's "Health Security bill," the Kennedy-Mills bill, and the Rockefeller Committee Report.

It has become increasingly clear that the present system is inequitable and irrational, denies access to millions of poor and minority citizens and suffers from uncontrollable costs and quality constraints. A program that will benefit all Americans — which means a national program — is unquestionably necessary. However, historically, national health and welfare legislation does not begin with congressional action; it ends there.

> Trying social policy at a lesser level before making it national policy was considered a stroke of genius.

Welfare and health services were intended to be initiated in the states, as ordered in the 10th Amendment to the Constitution: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states." Health and welfare were not mentioned as federal objectives in the Constitution. When welfare and health legislation begin in the states, the effects of the laws are tested and the laws amended, refined and polished there. After their utility and value are demonstrated, the state benefits are extended, by congressional action, to the entire nation.

For example, the elements of Social Security law existed in 24 states before the national Social Security Act was passed in 1935. The U.S. Congress didn't pass child labor legislation until 1912, yet by 1897 28 states already had child labor laws. The innovative American idea of trying a social policy at a lesser level before making it national policy was considered a stroke of genius by 19th century observers. The British scholar, Lord Bryce, commented, "A comparatively small commonwealth like an American state easily makes and unmakes its laws; mistakes are not serious, for they are soon corrected; other states profit by the experience of a law or a method which has worked well or ill in the state that has tried it."

Justice Brandeis implied that state initiatives might actually be requirements for eventual national action. "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens so choose, serve as a laboratory and try novel social and economic experiments without risk to the rest of the country."

Alice Rivlin, political and economic scholar, recommends strongly that social "innovation should be tried in enough places to establish its capacity to make a difference and the conditions under which it works best."

Where Congress has taken the initiative without previous state laws as guides — as in the Medicare law, which had no state model — the law is constantly being amended and is mired in controversy. The failure of states to undertake a first step in these times of enormous medical-care costs may be the result of lack of federal support. There are so many bits and pieces of health-services responsibility, all with separate funding and administration, that a new law would only be an added financial burden. If this factor were taken into consideration, an effort to fashion a national health program could be undertaken by Congress and some state legislatures, jointly.

Dr. Sullivan can, if he chooses, take account of legislative history and recommend the traditional approach by encouraging initiation of trial programs in one or more states. His report could propose substantial financial support for a state or states that wish to undertake pilot programs of state comprehensive health services, providing universal eligibility. The experience gained from the state programs in delivering a satisfactory level of medical care, in efficient and economical payment mechanisms and in quality would be used as the framework for the national health program everyone desperately wants. In this way we might indeed have a national health program in the 21st century.

George A. Silver, emeritus professor of public health at Yale, is writing a history of health policy in the United States.

Q1-1

The New England Journal of Medicine

Owned and Published by the
Massachusetts Medical Society

UNIVERSAL HEALTH INSURANCE: ITS TIME HAS COME

Over a year ago I said that "we urgently need a new and more comprehensive approach to health policy . . ." and noted that the National Leadership Commission on Health Care was planning to propose such an approach by the end of 1988.*

The Commission's report has not been released as of this writing, and when it is I expect to comment further. In the meantime, the *Journal* has published two other important contributions on this subject. In this issue and the last is a two-part description by Professor Alain Enthoven of his "Consumer-Choice Health Plan for the 1990s." This week we also publish a paper entitled "A National Health Program for the United States" by a group of physicians calling themselves "Physicians for a National Health Program." Both articles offer the outlines of a universal health insurance system designed to promote adequate coverage for all Americans, regardless of income or employment.

The Enthoven proposal is based on qualified managed care health plans that would compete for contracts with employers or state-level "public sponsors." The plans would presumably pay the hospitals. (Hospitals would also be paid by Medicare and Medicaid, which would continue under this proposal.) Employers would be required to cover all full-time employees and to pay an 8 percent payroll tax on the wages of all uncovered employees. Everyone not covered through employment would have to contribute through the income tax. Eighty percent of the average cost of premiums for basic approved coverage would be subsidized by the system, with the difference paid by beneficiaries according to their means; those with incomes below the poverty level would be totally subsidized by government. All costs of any more expensive coverage chosen by beneficiaries would be their responsibility.

*Relman AS. The National Leadership Commission on Health Care. N Engl J Med 1987; 317:706-7.

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Business, Subscription Offices: 1440 Main St., Waltham, MA 02154-1649.

hand, proposes a single public insurance system that would pay all health care costs from a common pool drawn at first from present mixed sources, with the recommendation that the federal government should ultimately assume total responsibility. State "National Health Program Payment Boards" would negotiate with all providers, paying hospitals an annual lump sum (plus separately budgeted capital expenditures), while physicians would be paid either through a "simplified binding fee schedule" or through salaries from HMOs that contracted with the payment boards for the delivery of comprehensive care on a capitation basis. Copayments or deductibles would be required, but coverage would be complete and totally funded by the national program. Private health insurance would be gradually phased out. Existing for-profit providers would be compensated by the payment boards, but no new investor-owned providers would be allowed.

There are important differences between these two approaches. Enthoven's tries to maintain the present pluralistic insurance network while providing for universal basic coverage and moving toward a case-management, prospective-payment system. The National Health Program opts for a monopsonistic universal-coverage insurance plan that would pay for all care without specifying how it should be provided. Neither one represents the socialization of health care, because the government would not own or operate health care facilities or employ physicians. However, it seems likely that under either proposal there would be major changes in the way most physicians would be paid. Salaried group practice would displace solo fee-for-service practice as the primary arrangement because the latter would not be as competitive economically.

These two proposals are not the first plans for universal health insurance to be advanced, nor will they be the last. It is hard to predict their fate, but it is safe to say that they and others like them will receive increasing attention from policy makers as they grope for ways to repair or replace our present disastrously inadequate health care financing system. In my view, nothing short of a comprehensive plan, which includes improved technology assessment and malpractice reform as well as other reforms in medical practice, is likely to achieve the goals of universal access, cost containment, and preservation of quality that everyone seems to want. The National Leadership Commission's report will address these wider issues.

Physicians will have to play an active and constructive part in shaping a new health care system, because no comprehensive arrangement is likely to succeed without their cooperation. Now is the time for our profession to make common cause with government and with the major private payers in seeking solutions to a pressing social problem that is not going to solve itself.

Arnold S. Relman, M.D.

11-1

Maturity

BORDERING ON COLLAPSE

Rising costs, stiffening barriers and planning inertia are making more and more of us health-care outcasts

By Constance Matthiessen

...n and I ...ple—including many children and grandchildren of the elderly—have no ...hi... all and as many as

Health Care In Crisis: Do We Need All We Use?

...on, we're getting older. And as many of us be- ...health-conscious, we are more likely than our ...k a doctor's attention.

...d home cures for new, more effective, more ...ations. We've replaced long-accepted con- ...g with remarkable medical breakthroughs. ...s, once treated with chicken soup and a ...s, now result in a visit to the pediatrician. ...of health care costs Americans more ...National Product. It's one reason ...increasing at near-crisis proportions.

"If You've Got It, Use It"

...surance intending to have a car ...buy fire insurance just to set ...coverage is different; perhaps ...e buy fully expecting to use. ...laime. Part of our half-cen- ...now them your card, we'll ...from the price of medical ...f the cost of premiums ...ive, use medical in- ...erage meet your ...rent" starts to "pay ...s.

...be done for more afflictions. Part of solving the use c... health care costs requires continued reassessment of the ... of medical treatment and the value received.

A Doctors' Perspective:

"Everything Known To Medical Science ..."

It's like a movie cliché. The family doctor shakes ... head and tells an anguished family, "We did ... do, but ..."

The number of diagnos... and procedures has ... disease and traum... scope. But unlik... purely lower...

Es... wh... and... proce... Fro... second... practice ... The an... be final. It's

The Canadian way: No medical bills

But could the U.S. adopt such a system?

By JAMES WORSHAM
Washington Correspondent

CRITICAL CONDITION

Under the ... Canadian health care sys... tem. ...

U.S. doctors' fees twice as high

Oct. 1990 K.C. Star

The Associated Press

BOSTON — Doctors in the United States charge more than twice as much as Canadian physicians for the same work, helping explain why this country's health care costs are dramatically higher, a study has concluded.

The study found that despite their higher fees, however, U.S. doctors earn only about one-third more than Canadians. The reason: Canadian doctors are busier and make up for their lower fees by seeing more patients.

Unlike the United States, Canada provides complete, fully paid ...alth coverage for all its citizens. ... one in seven

Overall, physician fees are 2.4 times higher in the United States than in Canada. Other factors besides doctors' earnings contribute to the lower cost of medical care in Canada.

two countries.

Overall, physician fees are 2.4 times higher in the United States than in Canada. Other factors besides doctors' earnings contribute to the lower cost of medical care in Canada.

"If physician fees in the United States were the same as in ... how much would total ... percent. If U.S. spending could be held to the Canadian percentage, more than $100 billion a year would be saved.

Fuchs' calculations, which converted Canadian figures into U.S. dollars, were published in today's issue of the *New England Journal of Medicine*.

The study was based on 1985 data. U.S. physician pay continues to climb sharply.

A survey by *Medical Economics* magazine found that U.S. physician incomes rose 12.5 percent in 1989, almost triple the rate of inflation.

Health care cost soaring

Commerce report warns that increases probably will continue.

By JAMES WORSHAM
Washington Correspondent

WASHINGTON — Health care costs for Americans will jump 12 ... n 1991, nearly three ... rate projected for ... flation, the Commerce ... forecast Sunday. ... the department's an- ...nual Outlook report ... even more ominous

... health care spending ...ally at 12 percent to ... the next five years ...ess introduces some ...

...increas... ...er t... ...n...

Mammography units exceed need

The Associated Press

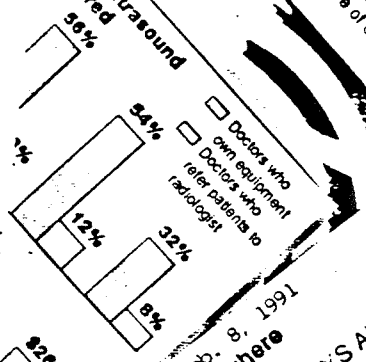
PHILADELPHIA — The Unit... has nearly four times the ... mammography ... contributing to ... cancer ...

"...situation in which more care does not mean better care, and it certainly is unlikely to mean more cost-effective care," said Dr. Alvin Mushlin of the University of Rochester Medical Center. Researchers estimate that each year, 150,000 American women develop breast cancer and about 30 percent ... die from the disea... cancer rates could ... about ... mammograms a ... National ... to ...

machines," Brown said. The high number of ... machine, keeping ... lowered ... could ... Thursday, December 6, 1990 The Kansas ...

Cost and frequency of patient X-rays

Compares frequency of X-rays ordered and patient cost by doctors who have their own X-ray equipment with those of doctors who send their patients to a radiologist



KANSAS INSURANCE LETTER - Feb. 8, 1991

Insurance News From Elsewhere

...EALTH CARE A GROWING BURDEN: SURVEY SAYS ANNUAL COST ... AN EMPLOYEE IS UP 17.1%, TO $3,217. The New York Times A su... conducted by A. Foster Higgins & Co., an employee benefit consultin... shows that companies are spending more for employee health care ... before. Among other things, the survey shows that last year abo... the average company's net earnings went towards medical exp... survey also shows that companies with 40,000 or more empl... per capita expenses than smaller firms.

...stripped-down health plans gain popularity

MANHATTAN MERCU...

...Illinois, Kentucky, Missou... Rhode Island, Virginia, ... Washington. The idea ... pected to catch on ... elsewhere.

The states hope that ... ployers and working ... will buy the les... plans, which cost ... month for an ind... percent to ...

...d coverage equals ... insurance pro... equation in- ...who are the ...esses at...

...rk Scott ...riter

1-62

JANUARY 28, 1991

Business Insurance®

Reporting ... for employee benefit and financial executives / $2.00 a copy; $80 a year

Firms devoting more funds to liability cover: RIMS study

NEW YORK—Corporate insurance buyers are spending proportionately more for liability insurance with higher limits than they did in 1984, while spending on property insurance is proportionately less, a new survey reports.

Insurance buyers also are spending proportionately less for workers compensation insurance, but employers have reported a large increase in self-funded workers comp losses, reports the 1990 Cost of Risk Survey by the Risk & Insur-

Continued on next page

Employers' health costs rise 17.1%

'90 increase larger than '89 hike: Study

By JERRY GEISEL

NEW YORK—Led by another ... creases in medical indemnity ... costs now exceed an average ... first time ever.

Total health care ... plans, health maintenance ... plans—leaped ... average from $... Foster Higgins ...

The 1990 ... both employers ... the 18th ... why ...

... of more than 20% in... ...s, group health care ...r employee for the ...

...al indemnity ... and vision ...ployee on ... by A. ...

up 25.5% from $3,187 in 1989.

For employers with 5,000 to 9,999 workers, the per-employee average also rose 25.5% to $3,410 from $2,717 in 1989.

However, employers with 500 to 999 employees saw their per-employee average rise only 10.5% to $3,140 in 1990 from $2,841 in 1989.

As was the case in 1989, the increase in total health care plan costs in 1990 was eclipsed by an even bigger leap in the cost of medical indemnity plans. An indemnity plan usually is an employer's largest health care-related benefit.

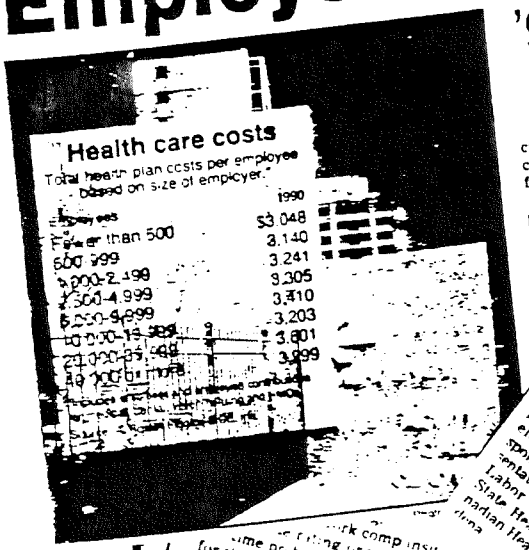
Indemnity plan costs climbed 21.6% among all employers in 1990 to $3,161 per employee from $2,600 in 1989.

The cost of insured indemnity plans climbed 26.2% to $3,290 per employee on average in 1990 from $2,608 in 1989, while the cost of self-funded indemnity plans increased 4% to $3,088 per employee from $2,587.

... 21.6% increase marks the second consecutive year during which indemnity plan costs have risen by more than 20%. ... plan costs had increased 20.4% to $2,600 in 1989 ... in 1988.

... rid pace of indemnity plan cost increases con... medical benefits for a single employee will ...

Continued on page 36



Garamendi vows health cover reform

By JOANNE WOJCIK

PASADENA, Calif.—In a dramatic presentation that began with a 60-minute segment on sick individuals denied coverage by health insurers, California's new insurance commissioner vowed to overhaul his department to promote insurance for all residents.

"You can imagine what I felt five or six days after I was elected and saw that on television," John Garamendi said, pointing to the screen where a "60 Minutes" segment titled "I Thought I Was Covered" had been broadcast a few minutes earlier.

Mr. Garamendi, who was inaugurated Jan. 7 as the state's first elected insurance commissioner, spoke to employer and labor representatives at the Jan. 17 "Business-Labor Organizing Conference on State Health Insurance and the Canadian Health Care System" in Pasa-

and health insurance is a disaster zone," Mr. Garamendi said.

But since his election as commissioner, "the Department of Insurance has changed," he said. "It is no longer a department for insurance companies. This department will use every power available to it to protect consumers in this state."

Mr. Garamendi also decried the fact that in a state that spends 12% of its gross domestic product on health care, so many residents are uninsured. Part of the commissioner's job, he said, is to ensure that all Californians have health insurance.

The Insurance Department has regulatory authority over about 30% of California's indemnity health insurance. Non-profit plans, like Blue Cross & Blue Shield plans, as well as health maintenance organizations are regulated by the Department of Corpora-

Although offering no specific plan, Mr. Garamendi ... libur Insurance Co., which is in liquidation.

Continued

ability to pay promptly, Mr. Garamendi said, pointing out that state law requires that health insurance claims be turned around in 30 days.

In addition, Masako Dotan, Mr. Garamendi's top legislative aide for 10 years, has been named deputy commissioner in charge of policy matters. She will coordinate legislation and research from the Sacramento office.

The new commissioner also said he will push for modifications in state laws to make health care more readily available and affordable. Such policies are usually purchased to convert group coverage to individual coverage.

"They shouldn't be that much more expensive or have significantly smaller benefits," he said.

Mr. Garamendi also vowed to promote regulations to fully enforce the Unfair Claims Practices Act, which the state Legislature passed in 1972.

California lawmaker offers bill to force statewide health cover

By JOANNE WOJCIK

PASADENA, Calif.—In an effort to put California on the map in terms of health insurance reform, a state legislator is proposing that employers offer a bare-bones health plan or pay a payroll tax to ... coverage for the ...

... minimum benefit requirements, will be ironed out in the Legislature, said Mr. Mar... lin.

The bill ... agreed ... comp ...

... et been as... ee because ... s were not ... until last ...

... les the ... which ... year. ... or a ... but ... m... ...uder dis... ...ily 9, 1990). ...ils, A.B. 14 ...ital health ...n told em... ...entatives at the "Business-Labor Organized Conference on State Health Insurance and the Canadian ... System," held Jan. 17.

Approximately 200 ... tended the event, which ... sponsored by 26 state and ... business and labor organi... The conference was presented ... the Edmund G. "Pat" Brown ... tute of Public Affairs at Califor... State University and the Jesse ... Unruh Institute of Politics at the University of Southern California.

"We have to make the system universal because we can't assure cost containment if the entire population isn't covered," Mr. Margolin argued. "Otherwise, there will continue to be cost-shifting" to

Continued on page 32

TOPEKA CAPITAL
WICHITA EAGLE

HAYS DAILY NEWS
HUTCHINSON NEWS

Small businesses ignore new insurance program

Second of three stories
By Mike Shields
Hearst News Service

TOPEKA — An estimated ...00,000 to 300,000 Kansans have ...o medical insurance and that ...umber is thought to be growing. So, legislators created a tax- ...t carrot they hoped would ...lowers of 25 or fewer ... the solution to ... Of the

"It seemed kind of complicated," said Gearld Bachamp, a Concordia body shop owner who looked the ... application over with his bookkeeper and tossed it aside.

What Butry, Bachamp and ... others received was an 11 p... packet from Fletcher Bell, the ... surance commissioner. It includ... two-page cover letter couch... polished bureaucratese, wit... mention of the tax ince... meant to attract the emplo...

1-13

Testimony before the Senate Public Health & Welfare Committee concerning SB 205.
February 27, 1991
Orville L. Voth, Speaker, Kansas Silver Haired Legislature.

Ordinarily when I offer testimony as a proponent of a piece of legislation I intend to give as unqualified support, together with adequate justification, as I can-representing the views of my constituency as I understand them. In the case of SB 205, however, I must limit endorsement to supporting the plan in principle. I represent the SHL today and that group has endorsed the idea of a comprehensive or universal health care system at the national level, largely I think, because that seemed more financially feasible. But the principle is essentially the same whether state or federally financed. We support the principle that affordable health care must be available to everyone.

There can be no doubt that the 'winds of change' in the health care system are blowing steadily and more strongly each year.Last year the Silver Haired Legislature wouldn't touch the issue. This year our SHL 711 passed by a two-thirds majority. Perhaps more weighty as signals of such change is the fact that over half of the nation's state legislatures have introduced proposals for public insurance, single-payer health care systems. The American College of Physicians and Physicians for a National Health Program have conducted studies, established criterea and made recommendations for such a health care system. On second thought, the SHL reversal of opinion on this issue over the last year may be quite significant in that it signals the readiness of people for major changes in the health care system...an openess that may be underestimated by legislators.

SB 205 is an excellent thrust in the right direction and warrants careful study and discussion. I agree with a recent statement by Dr. Bill Roy, "Senators Walker and Winter are on to something big...I believe the principles are correct." I urge you not to let this effort die in committee but, rather, that you keep alive and healthy, the principles of SB 205.

Thank you.

Senate P H&W
Attachment #2
2-27-91

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

February 26, 1991

TO: Senate Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: SENATE BILL 205

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 205. This bill would establish a program whereby all Kansans would have access to health insurance.

The problems facing our health care system are well documented. Hundreds of thousands of Kansans are without health insurance. Public programs cover only a portion of those persons with incomes below the federal poverty level. The cost of health care continues to rise at what most consider to be an unacceptable level. The cost of health care insurance for those who have it rises at an even higher level. Perhaps as important as any factor, our infant mortality rate does not compare favorably with that of many countries.

The question facing policymakers in the decade of the 1990s is not whether our health care system is broken; rather, the central issue is how to fix it. Senate Bill 205 provides a starting point for those discussions in Kansas. We support the central concepts behind Senate Bill 205 -- first, that all Kansans should have access to adequate and affordable health insurance; and second, that solutions to the problems faced by our current health delivery system should be part of a comprehensive plan addressing all aspects of the issue.

Certainly many of the particulars of SB 205 would need to be considered in more detail. For example, we believe that any health care system reform scenario should build on the strengths of a pluralistic health care delivery and financing system with a strategy for enhancing access to affordable, quality health care for all. Health care in a country as culturally diverse as ours is very much a local affair. What will work well in certain communities may be totally unfeasible or ill-advised in others. While the administrative

Senate P H&W
Attachment #3
2-27-91

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

3

NINE GOALS THAT A NEW HEALTH STRATEGY PLAN SHOULD MEET

- **Essential services available to all:** All individuals will have access to at least basic health care services.
- **High quality:** Delivery and financing arrangements will (1) ensure the effective management of medical conditions, particularly the coordination of care among providers and over time; (2) promote continuous improvement in the quality of care.
- **Affordable:** Patients and their purchasers will be able to select benefits and delivery arrangements that emphasize value, enabling them to obtain the kind of care for which they are willing and able to pay.
- **Adequately and fairly financed:** In order to eliminate cost-shifting, any public or private financing arrangement must itself bear the cost of the services provided to its enrollees or beneficiaries under the benefits it promises.
- **Efficiently delivered:** Delivery and financing systems will align the incentives of all providers wherever feasible to promote continuous improvement in the efficient use of resources to restore or preserve health, eliminating conflicts of interest and unnecessary duplication of services.
- **Community focused/patient centered:** Delivery and financing arrangements will be managed at the local level, recognizing appropriate community variations in medical practice consistent with: national standards for appropriate/effective treatment; health care needs; and resource availability.
- **In sufficient supply for timely access:** Delivery and financing arrangements will allow enrollees or beneficiaries to obtain care when and where it is most likely to change the course of a disease or prevent avoidable morbidity or mortality.
- **User-friendly:** Delivery and financing arrangements will enable patients, providers, and purchasers to obtain, deliver, and pay for care with minimum uncertainty and confusion; paperwork will be kept to a minimum.
- **Conducive to innovation:** Delivery and financing systems will promote development and dissemination of new and more effective methods of treating and preventing illnesses and delivering services.

* AHA: A NATIONAL HEALTH CARE STRATEGY:
A PLAN FOR CHANGE

costs of a pluralistic system of financing might be higher than a single governmental system such as Canada's, a pluralistic system of financing not only spurs innovation, but it enables health care costs to be spread among individuals, business, and government, rather than placing a single, massive burden on one funding source. More importantly, pluralistic financing facilitates local control over health care delivery, acknowledging variations in each area's resources and priorities.

The point, however, is that Senate Bill 205 is a beginning. Clearly, many discussions, debates and decisions must take place between now and the time a comprehensive plan is adopted. It is time for that process to begin.

In light of the fact that clearly no consensus can or will be reached this session on a comprehensive health care package, we recommend that SB 205 be held for further study.

Thank you for your consideration of our comments.

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

February 27, 1991

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society J. McGlotten

SUBJECT: Senate Bill 205; Access to Health Care

The Kansas Medical Society appreciates the opportunity to offer comments on SB 205, and the subject of health care insurance generally. The discussions surrounding availability and affordability of health care are not new, but are certainly more pronounced in recent times. Additionally, cost and access considerations are always interrelated.

In fact, one cannot adequately evaluate the problem of cost and access to care without taking a comprehensive look at the whole system. Every change that is imposed upon the health care system will have some resultant effect. For example, mandating benefits extends health care services to populations who might not otherwise have access to such services, but there is a corresponding cost. Another example is differential reimbursement rates in federal programs which discriminate against rural providers of care, thus providing disincentives for health care personnel and institutions to develop in rural areas.

The economic system in which health care is delivered in our country is unlike almost any other. The "consumer" (patient) is seldom the payor, as the overwhelming majority of care is purchased by third parties, whether they be health insurers, self-insured employer groups, government, etc. As government has become a larger purchaser of health care, it has discounted payments to providers in an effort to contain costs, which has resulted in enormous cost transfers to other payors in the private sector.

The growth of alternatives to traditional indemnity insurance, such as HMOs, PPOs and the whole array of "managed care" health plans have also had an effect. While some subsets of our population have benefitted from these alternatives, it can be argued that costs for the rest of the population have increased, as the base of population left in traditional plans has shrunk, making the risk-sharing pool smaller.

What about our ability to pay for advancing technology? Certainly, technology has been one of the key factors which have driven up health costs in recent years. However, technology has made it possible to extend lives and save lives where just a short time ago there was no hope. Add to this the demographic trends in our country which show a rapidly growing aged population, and one can only guess at the impact a graying America will have on an already technology-intensive health care delivery system.

Senate P H&W
Attachment #4
2-27-91

Some argue for expenditure limits and rationing of health care through some national or regional plan. As an academic exercise the concept seems fairly straightforward and simple. Yet to implement such a system in contemporary American culture where expectations and demands are high for access to a pluralistic system, would be difficult, if not impossible.

We applaud the willingness of the Legislature to look at our health insurance system on a broad scale. But, if you are looking for quick fixes or simple solutions, you simply will not find any. Countless study commissions and organizations countrywide for years have been wrestling with the difficult problems which surround the delivery of health care in our country. The problems are systemic, and have developed over several decades in an environment of the mixed messages which come from alternating incentives created by government regulation and market forces.

The provisions of SB 205, if enacted, would presumably address some of the major problems in our health care system. Those who are "uninsurable" (rejected by commercial carriers) would no longer be discriminated against, Medical Assistance patients would receive the same coverage as the rest of us, and thousands of Kansans who are currently medically indigent would be insured. These things would be accomplished by scrapping the traditional insurance mechanism and replacing it with a state agency. Because this concept would make such sweeping changes in both the financing and delivery of services, we cannot endorse the concept without thorough study. Yet, SB 205 serves as an excellent framework for substantive discussion. We compliment the authors for raising the important issues contained in SB 205, and we respectfully recommend that this bill be referred to the Joint Committee on Health Care Decisions for the 1990s to be a part of a comprehensive study on the structure of the health insurance system in Kansas. Thank you for the opportunity to present these comments.

CW:ns

William R. Roy, MD, JD

27 February 199.

Mr. Chairman, Distinguished Members of the Public Health Committee:

Thank you for the opportunity to testify as a proponent of Senate Bill 208.

I congratulate Senator Doug Walker and Senator Wint Winter for authoring and introducing this bill, which in my judgment is one of the most significant bill introduced in the 130 year history of the legislature. It promises landmark legislation, which indeed will come.

It is inhumane and inequitable to deny our citizens health care because of their inability to pay for services. It is unforgiveable to break people finacially and emotionally by great, unpayable medical and nursing home bills. Such is the situation today.

It is unwise and eventually destructive to our society to expend disproportionate amounts of our resources on health care. But today health care is threatening to devour private and public monies at a rate which will deny funds for other purposes such as education, environmental quality and a livable income.

The dilemma is how to improve access to health care services without breaking the bank. The two objectives are indeed diametrically opposed in our present free market-entrepeneurial health care system. Neither severe, oppressive regulation by public and private bodies nor attempts to establish a competitive market system have stemmed the tide of more services and more expensive services for fewer and fewer people.

Senators Walker and Winter have submitted to the legislature the key to expanding access and controlling costs while maintaining high quality services--universal health insurance based on the public insurance model used by most industrialized democracies.

The single most important component is the requirement for a single payor.

Only a single payor who negotiates annual global budgets for institutions, and also negotiates professional fees, can save tens of billions of dollars today spent for administration, and assure that the health care dollar is spent efficiently.

We recognize even single payor systems are and will be under expenditure pressures for the implementation of new technologies. But new technologies, properly used, can decrease as well as increase costs, as well as relieve suffering and postpone death.

Senate P H&W
Attachment #5
2-27-91

The other principles of the bill are generic, and hardly principles which can be denied. They are universal coverage which means all state residents must be covered by public insurance, or to put it conversely, no one should be left out.

The second principle is comprehensiveness--the insurance covers all necessary services. The bill also provides for the purchase of additional insurance for additional services. Determining what is necessary in medicine is a dynamic process, so the definition of necessary will change with time.

The third principle is portability, the insurance goes with the insured. Makes sense. And the fourth is accessability, which properly interpreted and implemented will be a blessing for rural Kansans.

Public insurance systems leave hospitals and the practice of medicine PRIVATE. Physicians will practice as they do today, and the hospitals will be owned by their present public or private owners. Also importantly, the Walker-Winter bill will stem the tide of employers or others "owning us," and dictating our physician and health care facility.

In my opinion there are deficiencies in the bill as written. They include an unecessary two tier system, somethimg less than a full time commissioners, coinsurance and maximum pay ceilings that are far too high, and the call for a payroll tax.

The system should be primarily financed by health insurance premiums paid by employers based on wages and salaries. You may say this is a distinction without a difference, and in part it is. But more importantly, paying insurance premiums is a part of American tradition and the continuing purchase of health insurance is much more acceptable to people than paying new taxes. There is about $2 billion of health insurance in Kansas today.

We are already paying taxes for the care of some of the poor, and there are current federal payroll taxes paying for Medicare for the elderly and disabled. These payments in Kansas in 1990 amounted to over $2 billion.

There are estimates of $2.2 billion being paid out of pocket for health care in Kansas today. Some of this is for private, nonpayroll associated health insurance. But add this to current federal and state expenditures, and employer supported health insurance and there is enough money to run the system--just run all monies through a single payor to control costs and make financial sense out of the system all ready in place.

There will be a great big bonus of about $600 million in Kansas which will come from cutting administrative costs by 10% of $6 billion. This will be available to expand services to the currently underserved--the uninsured who often get services with the costs surreptiously shifted to someone else.

It cannot be empnasized too strongly that the Walker-Winter bill is not a call for new expenditures for health care. Nor should they be necessary. Rather it is, as I hope I have illustrated, a call for the rerouteing and control of current huge expenditures all ready extracted from you and me...not someone behind the tree.

I am convinced that only with a perfected version of this bill can we avoid presently inevitable national health care costs of $1.5 trillion, ($15 billion in Kansas) by the year 2000. That amount comes to $5500 per person per year, a nearly impossible burden, and a huge expenditure that impacts adversely big and small business people, their employees, governments, and all of us.

Equally importantly only with legislation of this kind can we avoid the overt rationing of health care. We are in race between an economic, efficent, and fair health care system and rationing health care along the lines now being studied in Oregon.

There are barriers to the passage of this bill, but rest assured your constituents are not one of the barriers. I have good reasons to believe 60% of Kansans will support this kind of legislation, even--or especially after they get worked over by the special interests.

The barriers will be some hospitals and some doctors who probably at this time control the employees of their associations. While hospital people and physicians know something must be done, and done soon, they are threatened by negotiated budgets and fees, and therefore hope for a solution more amenable to their pocketbook interests.

A few private health insurers, and certainly the representatives of the Health Insurance Association of America will oppose the legislation. But not all insurance men and women, or even health insurance executives will oppose the bill.

Business and trade association representatives may oppose the legislation until they look at it closely. Then they will realize how threatened they are by the present system, its uncontrolled growth, and some proposed federal mandates, and at that time they will become enthusiastic supporters.

Most opponents to the legislation will support improving access to the poor and others who are left out. But always insist that they tell you HOW THEY WILL CONTROL COSTS--and I am reasonably sure you will hear at best only warmed over failed efforts of the past 20 years.

The greatest barrier to implementation of legislation of this kind are federal legislators who want to retain the power of controlling Medicare and Medicaid, who want to keep their average annual health interest PAC grants of $20,000 to $30,000 each, and who do not believe the states can do anything this big well--and that they can!??

Because over one-half of states are considering bills similar to this one (and very quickly it will be nearly all of the states), there is hope for wrenching health care jurisdiction and accompanying money away from the federal government and getting it into state hands. Capitation has already been established for Medicare, and Medicaid monies to the states all ready have established formulae.

In sum, a perfected Walker-Winter bill is the only hope I know of for expanding access and containing costs, of keeping a private health care system and avoiding overt rationing.

It should not require courage to support it--only courage to oppose it. Such legislation does require, however, careful study, understanding, and crafting, and I congratulate you for having set out on your way to do this.

Thank you.

Cure for unhealthy system

■ Health care in Kansas costs as much as all state and local government

I will spare you an essay "On becoming 65 years of age" (as of Feb. 23), because Roger Rosenblatt I am not. And Jane says all of those essays have been written.

Bill Roy

I will mention, however, that Part B of Medicare premiums for physicians' fees, and Plan 65, a Medicare supplement, add up to $170 per month, $2,040 per year; that the median income for citizens over 65 is less than $14,000 per year; that the average Medicare recipient pays over one-half of his or her medical bills out of pocket; that Medicare recipients spent more than one-half of their Social Security income on medical bills; and that our older citizens are paying a greater portion of their income for health care than they were before the establishment of Medicare over 25 years ago.

But Medicare recipients are better off than Esther and Tom Harold in Osage City who write, "We (are) in this awkward 50s age, before Medicare," and "cannot afford the $1,034 per month health insurance and are going to cancel. It is very scary to think of being without coverage."

The Harolds began private family coverage when "Tom lost his management job after 23 years with a prestigious Kansas City-based manufacturer. ... This was 1986 ... and the cost at that time was $1,296 per six month period."

With the nearly five-fold increase in premiums in five years the Harolds are priced out of the insurance market. They have searched diligently for alternative health insurance, but all would exclude pre-existing conditions and were "not worth taking the policy."

So here we have management class folks, now self-employed, who, through no fault of their own, are left out of our present entrepreneurial-free market health care system. They represent another nail in the coffin of America's overpriced, but often brutalizing, health care system.

Until someone shows me an alternative, I will contend we must go to a public insurance model system, so let's look at the flow of the nation's 660 billion health care dollars and our state's 6.6 billion health care dollars.

Here there is real sticker shock, because health care in Kansas today costs as much as all state and local government.

Yes, health care in Kansas in 1990 costs as much as primary and secondary education, plus state universities and community colleges; all law enforcement, sheriffs and city police and the Kansas Bureau of Investigation; all prisons and jails; all county roads and state highways; all zoos, city and state parks and recreational facilities; all welfare other than health care; the cost of running the city, county and state governments; economic development, and too many other things to print in 800 words.

The 50 state and all local governments cost 14.6 percent of the nation's gross national product, the value of all goods and services. But at least 20 percent of this 14.6 percent is spent on health care.

Thus the cost of local and state government without the health component is about 12 percent — the identical amount this nation is spending for health care. Next year health care will surge ahead in costs and with current trends will cost 1½ times the cost of state and local government by the end of the decade.

When we talk about the state paying for nearly all health care in a public insurance model, we are talking about doubling state expenditures! So that fact must be presented first, not glossed over or obscured.

If the nation spent $660 billion, the generally accepted number, for health care in 1990, then Kansas, with 1 percent of the population, should have spent $6.6 billion. We may have spent less, because our cost of living is less and we have a high percent of uninsured — or we may have spent more, because we have a relatively high percent of elderly.

Surprisingly, it isn't difficult to add up health care expenditures in Kansas to 100 percent of $6.6 billion. The state has issued a paper indicating it is spending $1.03 billion on health. Most of it, $409,406,086 (1990) is for Medicaid, an expensive but woefully inadequate program for the categorical poor. About $127 million is for health insurance for state employees, and the rest is for education of health professionals, state institutions and a lot of other things.

State expenditures, which include the federal match for Medicaid, represent more than 15 percent of health care expenditures in Kansas.

Employers are paying more, $2.2 billion, 33 percent. Remember Iola publisher Emerson Lynn's twice profits for health insurance and state Sen. Dick Bond's neighbor, the clothier, who pays $10,800 per employee per year.

But this one-third of Kansas' health expenditures, $2.2 billion, is distributed very unfairly. For example, fast-food restaurants are paying nothing for most of their employees. Some three-quarters of those without health insurance are frying hamburgers or doing similar near minimum wage jobs.

Another $1.8 billion is said to come out of pocket in direct payments — accounting for 27 percent. For comparison, this is an amount equal to over two-thirds of all taxes collected by the state of Kansas in 1990.

The federal government, if we use just the 1 percent ratio of Kansas' population, is channeling over $1 billion into the state for Medicare Payments. Thus we find another 15 percent of the $6.6 billion and reach a total of $6 billion dollars.

The other $600 million is expended for health care by the federal government. There are large Veterans Administration hospitals in the state, expenditures for the military personnel and dependents at Fort Riley, etc., federal research and education grants and other initiatives.

Governments at the federal, state and local level account for over 40 percent of health expenditures. The above $2 billion accounting for Medicare and Medicaid in Kansas falls $600 million short of the $2.6 billion, 40 percent portion of the $6.6 billion total Kansas expenditures, for which I am accounting. Throw that in, as I did above, and we come out right on the button.

There it is, $6.6 billion in 1990 health care expenditures for Kansas — all paid by you, 2.5 million fellow Kansans, at a rate of $2,640 per year for every man, woman and child.

Incidentally, 1990's $6.6 billion of health expenditures equals 14 percent of Kansas' 1988 $45.852 billion state domestic product and over 30 percent of Kansas' 1989 covered employees' wages of $20.2 billion.

All of you are paying something, if only sales taxes, that pays for health care. Many of you are paying too much. And 500,000 of you have no health insurance or Medicare or Medicaid — and the kids are sick and the wife is pregnant.

This wasteful, inequitable, unfair system calls out for dramatic change. That is why the Kansas Senate is holding hearings this week on a state universal, single payor health insurance bill.

Bill Roy is a local retired physician and former member of Congress.

TESTIMONY IN FAVOR OF SENATE BILL 205

February 26, 1991

My name is Katherine Pyle. I represent the Capital City Task Force and the State Legislative Committee of the Kansas AARP. Thank you for allowing me to offer my support for Senate Bill 205, the Kansas Health Care Act.

Our organization is convinced that access to health care, as well as the financing of health care, will constitute a major problem for the state and the nation throughout the 1990s. Four of the five legislative priorities established by AARP in Kansas this year deal with problems of the health care system. AARP is sponsoring a series of forums across Kansas and the nation to familiarize our members with the health care crisis and with the wide range of solutions that have been proposed to address that crisis. We believe that the disarray in our health care system has reached the point that something must be done about it soon. Therefore, we were delighted to learn that Senators Walker and Winter have submitted Senate Bill 205 to combat the rising costs and the striking inequities of our system of health care.

The advantages of this bill are many:

--The bill promises to put a brake on the rapidly escalating price of health care in the state by assigning to the health care commission the responsibility for approving new health care facilities, for approving the purchase of costly technology, and for negotiating the level of health care costs with institutions and professional organizations, .

--The bill promises to reduce dramatically the amount of costly paper work that will be required of health care providers and third party payers by establishing the health care commission as the single agent for payment of health care costs covered under Part 1 of the program.

--The bill will provide access to health care for individuals who are not now covered by adequate health insurance--comprising some 15% of our population--by including the entire population of the state within the program. Access to health care for those not adequately covered by insurance was one of the 1991 legislative priorities of the Kansas AARP.

--The bill commits the state to reliance on community-based long-term care, as compared to institutional care; this will rectify our present situation in which 92% of the funds spent on long-term care goes to nursing homes and related institutions. This change was another of our legislative priorities for 1991.

--By requiring the health care commission to collect data on the cost-effectiveness of health care providers, facilities, treatments, and technology, the bill suggests establishing a system for collecting and disseminating information regarding prices, quality of care,

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and patterns of use. Still another of our legislative priorities was the establishment of such a data collection system.

--The bill implies that the state will receive its full share of federal assistance for health care costs by directing the department of social and rehabilitation services to identify federal programs that provide federal funds for payment of health care services to individuals. Yet another of our legislative priorities was obtaining increased federal support for needed health care services in the state.

These and other provisions of the bill convince us that this is a major and much-needed step toward establishing in Kansas a rational and cost-effective health care system. We do have grave misgivings about one aspect of the bill: the establishment of a two-tiered health care system. Such a system will impede access by the poor, as compared to the well-to-do, to important health care services, thereby perpetuating some of the inequities of the present system. Despite this reservation, we applaud the introduction of Senate Bill 205. It is an important step toward an improved system of health care in the state. We strongly urge its approval by this committee.

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka
Topeka, Kansas 66612
(913) 234-5563

February 27, 1991

To: Chairman Ehrlich and Members, Senate Public Health Committee

From: Harold Riehm, Kansas Assoc. of Osteopathic Medicine

Subject: Comments -- and Support of Concept -- S.B. 205

We think S.B. 205 is an innovative and much needed starting point for discussion of a comprehensive plan to address health care problems, including the delivery of services, in the State of Kansas. As a starting point, it, of course, poses many problems. But we hope it commences the slow and deliberate process that will be necessary to comprehensively address these problems.

KAOM would recommend two subsequent follow-throughs:

(1) First, that S.B. 205 serve as a focal point for an Interim Study to review its application, implications and feasibility. Further, additional plans should be heard. The emphasis, however, should be on a comprehensive plan, rather than a piecemeal approach as has characterized past efforts.

(2) It is imperative, we think, that citizens of Kansas be brought into the planning process at the earliest possible time. KAOM would suggest a series of "TOWN MEETINGS" throughout Kansas, perhaps also commencing this summer, complementary to Legislative consideration. We would be pleased to participate in such meetings.

Again, we would raise numerous questions about specific provisions of S.B. 205 but that does not mean our opposition to the overall objective. We think it an excellent place to begin!

Thank you for this opportunity to comment on S.B. 205.

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2-27-91

My name is Judith Arentson. I have lived in Lawrence, Kansas for 34 years. I have been living as a single since 1984, when I divorced after 25 years of marriage. I have four adult children one of whom is a single adult son who is mentally ill. My ex-husband and I were self employed in sales for most of our married life with our business run out of our family home in Lawrence. My ex-husband moved to south Texas and the business was liquidated. I faced a forced retirement.

I am here today because I feel led to speak out as a victim who falls into an expensive crack with health insurance. I am currently in the big insurace cost category of 58 plus years. My current Blue Cross and Blue Shield plan - privately arranged for with no dental, no out patient prescription drugs and a $1,000 deductible, costs me a staggering $263. a month. This figure will move up to $300 plus when I reach 60 in 1992. In 1987, I was paying $152 a month, so in five years my premium will be doubled! I underwent serious major surgery in 1981 at KUMC and another surgery in 1988. Needless to say, I am now running scared. I have shopped around, but with pre-existing medical problems, I cannot get good coverage elsewhere. I cannot get medicare until age 65 or until a status of disability exists.

I have friends in similar circumstances who carry no or very inadequate medical insurance and pray they don't get sick. We all agree that a major illness or accident can wipe out your assets pretty fast. Now some of us can also add that the health insurance premiums will wipe us out slowly, too.

Medical costs across the board keep escalating annually at a much higher rate than inflation. A person like myself on a fixed income cannot afford rising medical insurance costs that must keep abreast of sky-rocketing hospital, drug, physician and lab costs.

What is desperately needed is a well thought out, comprehensive and affordable health insurance coverage plan for all citizens regardless of personal circumstances. I don't mind paying a reasonable amount of my income for health insurance, but what I am currently paying reflects a health insurance care system gone haywire with escalating costs. I feel victimized and discriminated against with no voice or opportunity for justice until this moment today. Please let our Kansas legislators create a comprehensive plan starting with SB 205 to include everyone in a design to equitably distribute health care insurance costs among all its citizens without discrimination. Thank you for this opportunity to share my concerns.

Judith Arentson
Tel: 913-842-0328

Senate P H&W
Attachment #8
2-27-91

KANSAS

NATIONAL ORGANIZATION FOR WOMEN

To: Senate Public Health & Welfare Committee

Re: S.B. 205

From: Kelly Kultala - National Organization for Women

The National Organization for Women wholeheartedly supports S.B. 205. This bill would provide statewide health insurance coverage for all residents of the state of Kansas. This is a bill whose time has come. Health care costs keep rising, making access a luxury instead of a basic right.

In 1987 the Federal Department of Health and Human Services compiled statistics from the National Medical Expenditure Survey (NMES) in regards to "A Profile of Uninsured Americans." The NMES survey indicated that 177 million Americans in the civilian, non-institutionalized population were covered by private health insurance and 24 million were covered by public programs. This left 37 million people uninsured in early 1987, representing 15.5 % of the population.

Gaps in insurance coverage were found among young adults, blacks and Hispanics, the unmarried and in families without a working adult. Low-wage or part-time workers, the self-employed, workers in industries with seasonal or temporary employment, and employees of small firms were likewise at higher than average risk of being uninsured. As much as 25% of adult workers under age 65 and their families lacked work-related coverage through employers or labor unions.

As members of this committee you will probably hear from big insurance companies telling you this plan can't work. Businesses across the state will tell you that they shouldn't be mandated to pay a surcharge to help fund this project or they just don't want to be told what benefits to offer their employees. And I'm sure that the Social and Rehabilitation Services Agency will kick and scream about losing certain federal funds that will in turn be deposited to the state treasury to be used by this to be established, Kansas health care trust fund.

However, it is imperative that you pay attention to the statistics and listen to the people of Kansas. They are the ones who need your help and your representation at the State Capitol.

In conclusion, we would like to make a suggestion on page 4, lines 21 & 22. Where the line says "...increased reliance on primary and preventive care..." it should include "... birth control upon request for all men and women in the State of Kansas."

Senate P H&W
Attachment #9
2-27-91

KANSAS
ASSOCIATION OF
PUBLIC EMPLOYEES

Presentation to
Committee on Public Health and Welfare
by
Charles Dodson
Kansas Association of Public Employees

Mr. Chairman, members of the Committee, thank you for giving me the opportunity to briefly speak in favor of far-reaching changes to our health care funding system. I cannot claim to be knowledgeable as to the changes necessary.

The bill before you today leaves me with many unanswered questions. However, the scope of the changes promoted by this SB 205 are probably in line with what will be necessary to grasp a solution.

I am aware that hundreds of state employees do not have insurance coverage for their families. They simply can't afford it. Yet the premium for state workers is modest by many private sector policy standards. We are rapidly approaching the time when two people in each family will be required to work - one for income, one for health insurance.

This issue begs for serious consideration. During the past twenty years, 1970-1990, the cost of health insurance for state employees, according to a report of the Legislative Research Department, dated October 9. 1990 (attached), has increased 2,993.8%. If this figure is adjusted for the growth in state government, the adjusted growth is still 1,890%. If that continues, the 68.5 million we spent in 1990 for health coverage for state employees will exceed $1.2 billion by 2010.

Our system has run amuck. Right now, every one blames everyone for the high costs. Doctors, Hospitals, Insurers and Insured are all certain it is the other's fault.

It is no longer just a matter of costs in dollars and cents. People are dying, people are permanently scarred because they do not have adequate access to the system. Someone or some group must emerge as leaders. Why not you?

Thank you for allowing me to speak with you.

Senate P H&W
Attachment #10
2-27-91

400 West 8th Ave. Suite #103 Topeka, Kansas 66603 913-235-0262

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TRENDS IN SELECTED SALARIES AND WAGES EXPENDITURES
ALL FUNDS
(Dollars in Thousands; Nominal and Adjusted to FY 1990 Dollars, As Measured by CPI-U)

	FY 1970	FY 1975	FY 1980	FY 1985	FY 1990	Increase FY 1990/ FY 1970
Classified Employees						
Nominal Amount	$ 130,434	$ 198,806	$ 319,527	$ 459,873	$ 648,410	$517,976
Percent Increase	–%	52.4%	60.7%	43.9%	41.0%	397.1%
Adjusted Amount	438,258	487,472	523,066	551,848	648,410	210,152
Percent Increase	–	11.2	7.3	5.5	17.5	48.0
Unclassified Employees						
Nominal Amount	77,431	114,987	198,399	279,041	396,963	319,532
Percent Increase	–	48.5	72.5	40.6	42.3	412.7
Adjusted Amount	260,168	281,948	324,779	334,849	396,963	136,795
Percent Increase	–	8.4	15.2	3.1	18.6	52.6
Student Employees						
Nominal Amount	9,408	15,359	26,985	33,671	47,896	38,488
Percent Increase	–	63.3	75.7	24.8	42.2	409.1
Adjusted Amount	31,611	37,660	44,174	40,405	47,896	16,285
Percent Increase	–	19.1	17.3	(8.5)	18.5	51.5
All Salaries, Excl. Contrib.						
Nominal Amount	218,069	330,610	546,521	774,858	1,097,194	879,125
Percent Increase	–	51.6	65.3	41.8	41.6	403.1
Adjusted Amount	732,712	810,656	894,655	929,830	1,097,194	364,482
Percent Increase	–	10.6	10.4	3.9	18.0	49.7
RS Plans*						
minal Amount	8,747	16,376	22,310	26,628	27,368	18,621
Percent Increase	–	87.2	36.2	19.4	2.8	212.9
Adjusted Amount	29,390	40,154	36,521	31,953	27,368	(2.0)
Percent Increase	–	36.6	(9.0)	(12.5)	(14.3)	(6.9)
Regents TIAA/CREF						
Nominal Amount	1,858	2,900	5,795	8,656	19,536	17,678
Percent Increase	–	56.1	99.8	49.4	125.7	951.5
Adjusted Amount	6,243	7,111	9,486	10,387	19,536	13,293
Percent Increase	–	13.9	33.4	9.5	88.1	212.9
Social Security						
Nominal Amount	8,119	16,549	29,662	49,442	74,012	65,893
Percent Increase	–	103.8	79.2	66.7	49.7	811.6
Adjusted Amount	27,280	40,578	48,557	59,330	74,012	46,732
Percent Increase	–	48.7	19.7	22.2	24.7	171.3
Health Insurance						
Nominal Amount	2,290	5,354	15,086	34,870	70,847	68,557
Percent Increase	–	133.8	181.8	131.1	103.2	2,993.8
Adjusted Amount	7,694	13,128	24,696	41,844	70,847	63,153
Percent Increase	–	70.6	88.1	69.4	69.3	820.8
All Salaries and Wages						
Nominal Amount	239,446	373,500	623,479	902,913	1,304,824	1,065,378
Percent Increase	–	56.0	66.9	44.8	44.5	444.9
Adjusted Amount	804,539	915,822	1,020,635	1,083,495	1,304,824	500,285
Percent Increase	–	13.8	11.4	6.2	20.4	62.2

*ludes deferred compensation paid by state in lieu of KPER membership.

90-806/ea

10-2

LEAGUE OF WOMEN VOTERS OF KANSAS

919½ South Kansas Avenue, Topeka, Kansas 66612 (913) 234-5152

SENATE PUBLIC ~~HEALTH~~ Ways & Means & WELFARE
Senator ~~Doug Walker~~, Chairman
February 27, 1991

I'm Myrna Stringer, speaking on behalf of League of Women Voters of Kansas.

League of Women Voters of Kansas would like to go on record in support of the concepts included in Senate Bill 205, specifically under Section 4 (a) 6:

> "study and implementation of the most cost effective methods of providing comprehensive personal health services to all persons within this state, including increased reliance on primary and preventive care, community-based alternatives to institutional long-term careand increased emphasis on alternative providers and modes of care."

If a universal health care plan can provide up front primary and preventive health care for everyone in the state, the access issue is resolved; if the cost is based on ability to pay the affordability issue is answered.

We believe the state could spend no more than it is now spending on health care through the various programs it is trying to fund and in the long term would be able to cut back because basic, early access and preventive care simply is not as expensive as emergency room and crisis care.

The report--now a year old-- on Access To Services for the Medically Indigent and Homeless states "whether one views health care as a right or as a good investment, all Kansans should have access to a clearly defined set of basic health care services."

League of Women Voters of Kansas adopted a Medical Indigence position statement in February of 1989 which states that basic health care should be available to all citizens of Kansas; individuals should provide for their own care when feasible and affordable, though we recognize that some people are medically indigent, that is, uninsured, underinsured or for some reason unable to pay for health care. Our position also states: In the absence of federal action, the state should take the responsibility for devising a plan to care for the medically indigent in Kansas and that the state has the primary responsibility for providing funding and program guidelines for health care and health education.

Thank you.

Senate P H&W
Attachment #11
2-27-91

NATIONAL HEALTH PLANNING

1. NEED

3 High infant mortality - U.S.-11/1000, Canada-10/1000, Japan-6/1000, D.C.-21/1000
1 High cost - % of GDP-U.S.-10.6, Germany, Canada-8.2, U.K.- 5.9
High cost of administration. For a given procedure 14¢ in Saskatchewan; $1.76 in USA
15% U.S. lack coverage. 0% in Canada.
2 Unique among industrialized nations without national plan.

2. HISTORICAL DEVELOPMENT

Compacts of various kinds. Montreal Dr. 1665- 26 families
1883 - Nova Scotia miners covered by wage deduction.
1914 - Special tax Sarnia, Sask. to support GP.
1930 - Municipal plans mounted
1935 - Federal Bill unconstitutional
1947 - Provincial plan (Sask) total coverage for hospitalizatic
1949 - BC plan
1957 - Federal plan enacted. Provides 50% provincial costs
1958 - Government plan re. doctors
1962 - Dr. Strike 23 days Br. MDs recruited resistance from delivery system
1966 - Federal Plan supporting provincial plans
1971 - All 10 provinces in the plan
1984 - Act to re-authorize federal plan

CURRENT SITUATION

a. Canada resembles most plans

I. Development from small, local groups (1930) through Provincial (1940) to National scheme (1950). Hospital insurance first. Physicians care 1962 (Strike).
Federal act 1971
Canada Health Act 1984 reinshrines the system.

II. Finance

Doctor to client early practice
Local groupings - cost sharing
Provincial payment (100% Sask.)
Post 1957 - 50% from Federal "Prospective" (global) budgeting Medicare (Can.) instituted 1962.

Senate P H&W
Attachment #12
2-27-91

Hospitals in 3 categories
Health centers
School health
Medical education

IV. Auxiliary services

dental
pharmaceutical
mental health
rehabilitation
nursing

V. General

Surveilance
Training - G.P. vs specialists

b. Poland. Services provided traditionally by local organization (Govt.). Wide and diversified services with major funding from central govt. Responsibility for "hands on" service at local level (ZOZ localized unit of standard population size). Health personnel assigned to schools, factories, etc. Auxiliary personnel available. Surveillance of quality of service at all levels. Ethical code prepared by Polish Medical Assoc. High availability of health personnel and facilities.

Some anecdotes:

Florence Hornby - MS
Lenore Wright - Junior Rheumetoid Arthritis
California citizen moved to B.C. to be under Canada system (arthritis) - Grey Panther Network report.
Buffalo N.Y. angiogram to cost $2200.00. Free in Niagra Falls, Can. AARP - Reader Forum.

Recommendations:

100% coverage. 15% uninsured; more underinsured
Prospective budgeting . Remuneration set by annual bargaining.
Attitude changes. Plan to serve clients more than doctors.
Ratio of specialists to GP to change.
Provision of auxilliary services within the plan.
Arrangement of facilities according to plan. Health centers in national plan.
Services to pre natal, post partum, early childhood, in school clients.
Local units to retain high level of control. Federal regulation kept to minimum

Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

Office Phone
913/233-7483

To: Senate Committee on Public Health and Welfare

Re: Senate Bill No. 205

It is requested that this bill be amended by adding the following words:

"The plan shall include benefits comparable to medical benefits for those who rely upon spiritual means through prayer alone in accordance with a recognized religious method of healing permitted under the laws of this state."

Adding this provision will allow those who rely on spiritual healing to participate in the benefits of the plan. This seems fair because they certainly will not be excused from the required payments to support the plan.

Massachusetts, the only state with a similar plan in its statutes, does provide for payment where spiritual treatment is chosen in lieu of medical care. I understand that this plan has not yet been implemented and may be delayed by state financial problems.

I'm not sure where our proposed amendment can be inserted. I have confidence that the Revisor can find an appropriate location.

Keith R. Landis
Committee on Publication
for Kansas

Senate P H&W
Attachment #13
2-27-91

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KANSAS DEPARTMENT OF HUMAN RESOURCES

Commission on Disability Concerns
1430 S.W. Topeka Boulevard, Topeka, Kansas 66612-1877
913-296-1722 (Voice) -- 913-296-5044 (TDD)
913-296-4065 (Fax)

Joan Finney, Governor

Michael L. Johnston, Secretary

February 27, 1991

TESTIMONY ON SENATE BILL 205 BY KEVIN SIEK
KANSAS COMMISSION ON DISABILITY CONCERNS

Thank you for the opportunity to testify on SB 205 an act to provide affordable health care for all Kansans. The opinions expressed in this testimony are those of the Kansas Commission on Disability Concerns (KCDC) and are not necessarily those of the administration.

KCDC supports legislation that would guarantee affordable comprehensive health care to all Kansans regardless of income or medical condition. Today 37 million Americans, nearly one in six, have no health insurance. Of that 37 million, two thirds are workers or their dependents. These people are too wealthy to qualify for Medicaid and to poor to buy health insurance.

To many others the three most chilling words in the English language are "pre-existing medical condition". Nearly 25 percent of people with chronic diseases like diabetes, cerebral palsy and multiple sclerosis have been denied health insurance. Ironically, they are "too sick" to get health insurance.

Many of the people that make up the statistics I have just mentioned are our fellow Kansans. Doctors, health care providers, business, labor and health care consumers all agree that our health care system is critically in need of reform. KCDC believes that SB 205 is a positive step in that direction.

For a system like that proposed in SB 205 to be successful the people of Kansas must first decide exactly what their health care priorities are. Across the nation from Oregon to Maine, in various ways, other states are doing or have already done just that. However we decide to make these important decisions in Kansas it is imperative that there be as much consumer input as possible.

KCDC believes that SB 205 can be a good framework on which we can build an equitable, affordable and comprehensive health care system for all Kansans, but it is also an extremely complex problem that will require careful study and input from all aspects of our society. KCDC feels that these issues can best be resolved in an interim study that would examine what type of universal health care system best suits our state and what the health care priorities really are in Kansas.

Senate P H&W
Attachment #14
2-27-91

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Testimony presented to

Senate Public Health and Welfare

by

The Kansas Department of Health and Environment

Senate Bill 205

Mr. Chairman and members of the committee I thank you for the opportunity to testify today on SB 205. This bill proposes to establish a statewide health insurance program for all residents of Kansas. It mandates that the health insurance program is to "provide comprehensive coverage for all necessary health care services for all residents of Kansas". In addition it will mandate that every family covered under the plan will have a copayment responsibility for covered services under the plan. A 21 member public commission would be established to administer the insurance program. The primary functions of the commission are to administer the insurance plan and to define what are comprehensive, necessary personal health services.

This bill is in response to two primary problems with the health delivery system in Kansas-

1. At least 375,000 Kansans do not have access to comprehensive primary care services and
2. health care costs are escalating at more than twice the rate of inflation.

KDHE applauds the effort represented by this bill to cope with the two major issues of lack of access and skyrocketing health care costs.

The Department of Health and Environment has recently been awarded a grant from the U. S. Public Health Service for the development of systems to assure access for the medically indigent for primary care services in Kansas. In assessing proposed solutions to the access problem, we have focused on three policy guidelines

1. Solutions must provide comprehensive primary care.
2. Solutions must be integrated into the existing delivery system.
3. Solutions must maximize federal revenue.

While our efforts have been focused only on outpatient primary care, these three policy goals are relevant for any proposal to provide access to health services for all Kansans. SB 205 will assure that these three policy goals are met.

Senate P H&W
Attachment #15
2-27-91

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In analyzing the detail of the bill we have four areas of concern to share with the committee. The first and most problematic is the definition of "comprehensive, necessary health care services for all residents". We believe that the law ought to establish more specifically the range of services both inpatient and outpatient that should be considered for inclusion in the plan. At the core of the cost issue is not whether to ration services to citizens in the state for we already do that, but how we as a society make those rationing choices. The parameters for those choices ought to be imbedded in statue.

The second issue is a concern about how this bill will impede not enhance access to care. The bill mandates a copayment for all services for each and every resident. Mandating a copayment for all preventive services including screening exams may discourage usage of these cost effective interventions. The concept of requiring copayment may be a useful one but its use in assuring maximum use of preventive services and the mandated rate schedule need a review for both effectiveness and fairness to all citizens.

Our third concern is one of the capacity of the system to absorb an additional 375,000 patients. The current health professions training system does not place a high priority on training primary care providers. Currently not enough primary care physicians, nurse practitioners, physicians assistants or public health professionals are being trained to meet the demand. The health professions training fund created by the bill ought to focus a significant portion of the funds for the training of the primary care providers.

Our final concern is with the rural health delivery system. Without changes in the delivery system and health professions training programs, there will still be an access problem for rural Kansans. Many preventive and community based services are inadequate or non-existent in rural Kansas. The development of rural health community delivery models coupled with an increased emphasis on training health professionals to practice in primary care in rural settings will need to be continued even if the economic access barrier is removed.

In conclusion KDHE believes that it is time to address the difficult issues of access and cost of health care and welcomes the opportunity to participate in this most important dialogue toward seeking effective solutions.

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