Approved 3-5-91
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

10:00 a.m./p.m. on February 28, 1991 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisor's Office
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

John Knack, Blue Cross and Blue Shield
LewJene Schneider, Health Insurance Association of America
Alan F. Alderson, Counsel for Tobacco Institute
Ronald Hein, R. J. Reynolds Tobacco
Terry Leatherman, Kansas Chamber of Commerce and Industry
James P. Schwartz, Jr., Kansas Employer Coalition on Health, Inc.
Senator Nancy Parrish

Chairman Ehrlich called the meeting to order at 10:00 a.m. announcing continued hearing on SB 205 - Health Care for Kansans.

Appearing in opposition to SB 205 and submitting written testimony was John Knack, Blue Cross and Blue Shield. He stated he was an opponent of the bill, however, he was not taking this stance because of a belief that change is not needed. The organizations that he represents have taken a proactive position regarding the necessity for change as demonstrated by their participation in and support of the Governor's Commission on Health Care Report, the Kansas Employer's Coalition on Health White Paper on Reform of the Health Care System, and interim study committees dealing with health and financing issues. He highlighted several issues that were recommended by the Governor's Commission on Health Care, and encouraged members of the committee to consider those approaches to health care reform. Most of the recommendations are currently being presented to the legislature in the form of HB 2001, SB 179 and SB 229. (Attachment 1) Mr. Knack was questioned by Senator Walker if he would be testifying on HB 2001 and SB 179 and why he had not implemented recommendations previously. Senator Walker called attention to the fact since Blue Cross and Blue Shield had 35% share of the health insurance market, why hadn't they taken a leadership position on this earlier. Committee discussion centered on supplemental coverage, number of studies being conducted, deductible and copayment coverage, and the role Blue Cross and Blue Shield would take if this bill passed.

LewJene Schneider, Health Insurance Association of America, presented written testimony and spoke in opposition to SB 205 stating HIAA shares the concerns of the Kansas legislature, employers and consumers regarding the high cost of health care in the United States, but SB 205 would not make significant contributions toward solving the initial problem, which is cost containment. Ms. Schneider pointed out the Canadian health care system suffers access problems and waiting lists for certain kinds of care in some parts of the country. (Attachment 2)

Alan Alderson, appeared on behalf of the Tobacco Institute, and submitted written testimony in opposition to SB 205. Since the bill indicates that a surcharge equal to ten percent of the retail price of tobacco products would be levied on the sale at retail of cigarettes, cigars, snuff and other tobacco products, he is opposed to the bill. He also stated earmarking tobacco products taxes is not only an unfair tax policy, but unwise. He

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

also pointed out a ten percent surcharge on the retail cost of a pack of cigarettes would drive consumers to Missouri to buy their tobacco products. (Attachment 3 Senator Walker pointed out this is a health issue, not a tax issue. He referred to statistics dealing with deaths caused from smoking, and since the tobacco industry has been part of the health problem, they should now be part of the solution. Senator Kanan also pointed out consumers in Kansas do cross the Missouri line for their tobacco products.

Ron Hein, representing R.J. Reynolds Tobacco Company, presented written testimony and appeared in opposition to SB 205, stating the bill is a general tax increase on the citizens of this state. He would like to see the funding for this bill if passed, come from the state general fund. (Attachment 4)

Terry Leatherman, Kansas Chamber of Commerce and Industry, submitted written testimony and appeared in opposition to SB 205. He stated the Chamber cannot support SB 205 at this time because of the requirement for all Kansas employers to pay a health premium surcharge equal to eight percent of all wages paid to employees; however, KCCI looks forward to joining other organizations involved in the health care delivery process in working with the legislature in the health care area. (Attachment 5)

Jim Schwartz, consulting director for the Kansas Employer Coalition on Health, submitted written testimony and spoke in opposition to SB 205. He stated while his organization does support most of the aims of the bill, they basically feel the bill goes needlessly far in placing the reins of the health care system into the hands of the public sector. He further stated the bill calls for the funding of basic health care for all Kansans through a single public entity and that most Kansas employers are uncomfortable with that kind of public authority over a sensitive human-service system like health care. He concluded by stating he would like to see the bill made a priority item for interim study. (Attachment 6) Senator Hayden questioned if his organization feels the same way about funding unemployment compensation, workers compensation and social security as they do about the health care funding plan offered in this bill.

Written testimony in opposition to SB 205 was also distributed to the committee from Bill Sneed, legislative counsel for the Smokeless Tobacco Council, Inc. (Attachment 7)

Chairman Ehrlich announced that Senator Wint Winter requested SB 182, scheduled to be heard today, be postponed because several groups interested in the bill would be meeting and reconcile their differences. Copies of Senator Winter's Memo were distributed to the committee.

Hearing on:

SB 235 - Standards for bottled water.

Senator Nancy Parrish, sponsor of SB 235, appeared in support of her bill and submitted a brief of the bill. The bill would adopt standards for bottled water. (Attachment 8) Senator Parrish introduced Susan Self, who appeared before the committee and expressed her concern of inferior water products being sold in stores and a need for the consumer to know the content of the bottled water.

Submitting written testimony on SB 235 was Stephen N. Paige, Director, Bureau of Environmental Health Services of the Department of Health and Environment. His testimony stated the department supports favorable consideration of the bill, but feels there are three issues needing clarification: (1) water sampling by qualified personnel, (2) reporting of non-compliance with regard to contamination, and (3) there are no sanctions for non-compliance. (Attachment 9)

The meeting was adjourned at 11:05 p.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-28-91

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Charles Smyth	KS Foundation for Medical Care
Martha Gabehart	Ks. Com. on Disability Concerns
Peter Cerf	KINH
Matt Truell	AP
Deana Keele, Nursing	Pittsburg, Ks.
Stephen N. Paige	KDHE
Lori Fuhrmande	—
Ron Hein	RJR
Sherri Holliday	Budget Division
Kelly Kultala	NOW
L Schneider	HIAA
Jim Schwartz	KECH
John Knack	BC/BS of Kansas
Nancy Hammel	Clay Center Ks
Kris Gottschalk	intern
Alice D. Hixson	A.A.R.P. Capt City Task Force
Terry Leatherman	KCCI
Nancy Parrish	Senate
Dalyrt Sh Jane	KWO

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE ____________________

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Bill Pitsenberger	Blue Cross
ALAN ALDERSON	TOBACCO INSTITUTE
Tom Gress	KHA
Susan J. Seif	Bottled Water

TESTIMONY ON SENATE BILL 205
BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.
SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
FEBRUARY 27, 1991

Mr. Chairman, members of the committee, my name is John Knack and I serve as Executive Vice President of Blue Cross and Blue Shield of Kansas and Executive Director of HMO Kansas.

I am testifying today as an opponent of Senate Bill 205. However, I am not taking this stance because of a belief that change is not needed in our current system of delivering and financing health care services. Actually, the organizations I represent have taken a pro-active position regarding the necessity for change as demonstrated by our participation in and support of the Governor's Commission on Health Care Report, the Kansas Employer's Coalition on Health White Paper on Reform of the Health Care System, and interim study committees dealing with health and financing issues. Our conclusion is that no change is not an option.

We acknowledge that health care issues are extremely complex and when dealing with such complex issues, the tendency is to seek a simple solution. The most frequent response is to turn the problem over to the government. This occurred in the mid-1960's when Medicare and Medicaid were created as single payor systems. Each promised access to health care for covered citizens and we were assured that the cost of these programs was not going to be burdensome. As Attachment A demonstrates, the Medicare program is faring no better than our current private system in controlling costs and Medicaid is certainly not a program that one can point to as a successful single payor model.

In fact, if the government were not involved in shifting many of the costs of these programs to the private sector, the lack of results would be more dramatic. I, for one, am not convinced that single payor systems have demonstrated a successful cure for what ails us.

Senate P H&W
Attachment #1
2-28-91

Given this scenario, we have chosen to apply our efforts to a pluralistic solution involving not only the federal and state governments, but also private sector participants.

As I mentioned earlier, the Kansas Employer Coalition on Health and the Governor's Commission on Health Care have introduced recommendations that deserve serious consideration. As a participant in both projects, I can attest to the thought, effort, and compromise involved.

Both documents are similar in content, however, the KECH proposal represents a national approach to comprehensive reform while the Governor's Commission focused on our local environment. As a result, I would like to outline the latter approach.

The Commission on Health Care recommended that Kansas implement a three-phased program designed to:

- Make health care coverage accessible to all Kansans.

- Spread the ever-increasing cost of health care services across a wider population and thus make health care financing more affordable to more citizens.

- Encourage more efficient and wiser use of health care services through incentives and disincentives in the mechanisms used to finance health care.

Phase I. The first phase is designed to create parity for all insurers and insureds that would result in a realistic approach to make available coverage for all small groups or businesses in Kansas. As part of Phase I the following strategies address insurers insuring employee groups of 50 or less employees:

- Every insurance company must develop a community rate for all businesses they enroll with 50 or less employees.

- o Prohibit exclusion of employees from a group due to pre-existing medical conditions (beyond eight months) at the formation of a newly enrolled group or business.

- o Require provisions that assure portability of coverage should employees change employment and move from one small group to another.

- o Prohibit insurers from excluding any employer group wishing to enroll.

- o Grant insurers the ability to subrogate and coordinate benefits.

- o Subject all insurers to the same insurance provisions.

- o Regulate all insurers equally.

- o Implement rate regulation for all insurers.

- o Support and promote the implementation of H.B. 2610 and expand the program to cover employers with less than 50 employees.

- o Repeal legislative mandates for small businesses.

Phase I does not propose any requirement for participation but merely expects Kansas businesses to volunteer to provide health insurance for their employees. It would appear that incentives at this stage would be necessary.

Phase II. The second phase is designed to expand the availability of coverage beyond small groups to include the unemployed under age 65, the self-employed, and the medically uninsurable.

- o Provide a Medicaid "buy-in" option for individuals not eligible for Medicaid with annual incomes not exceeding 150% of the state poverty level.

o Provide a Medicaid "buy-in" option for individuals unable to purchase health insurance due to medical conditions.

An alternative to making the Medicaid buy-in available to the medically uninsurable persons would be to develop a statewide uninsurable risk pool.

Phase III. Members of the Commission believed that the implementation of Phase I and II would be a step forward in increasing the availability to many Kansans that now find they cannot avail themselves of health insurance. Phase III is recommended for future implementation and is designed to assure universal access to health care coverage through the offering of:

o Employer mandated health insurance
  Attachment B is an article appearing in the February 18, 1991 issue of Business Insurance which reflects the growing acceptance of this approach versus a governmental (single payor) system.

o Statewide pools for self-employed individuals and others not covered by group insurance

This proposal builds on an existing framework rather than abandoning an entire approach which allows for a more natural transition to health care reform. Most of the recommendations contained within this report are currently being presented to the Legislature in the form of House Bill 2001, Senate Bill 179, and Senate Bill 229.

We encourage members of this committee and other legislators to consider these meaningful and more moderate approaches to health care reform.

JWK/lsh
Attachment

ATTACHMENT A

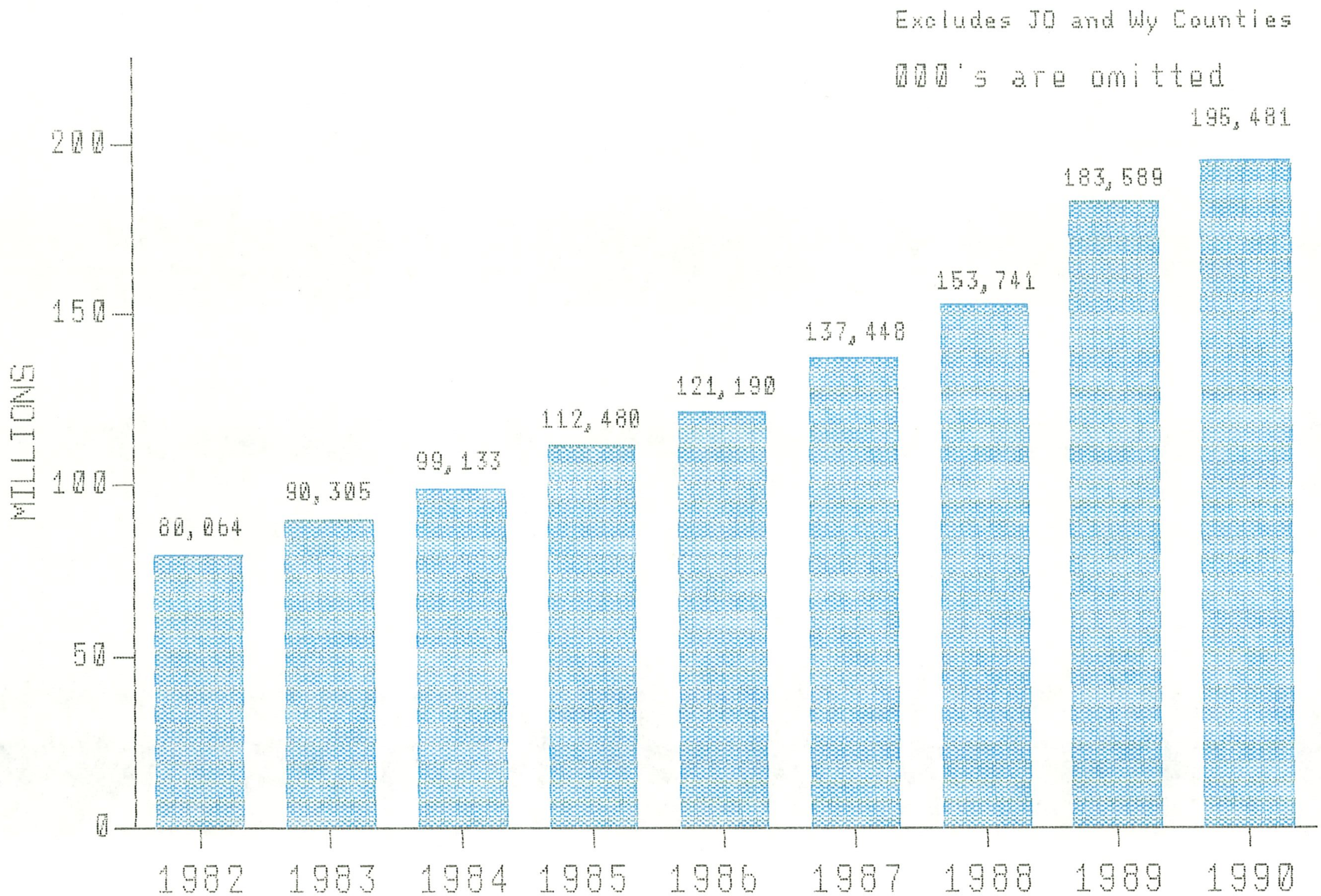
Medicare Professional Claims Experience

1982-1990

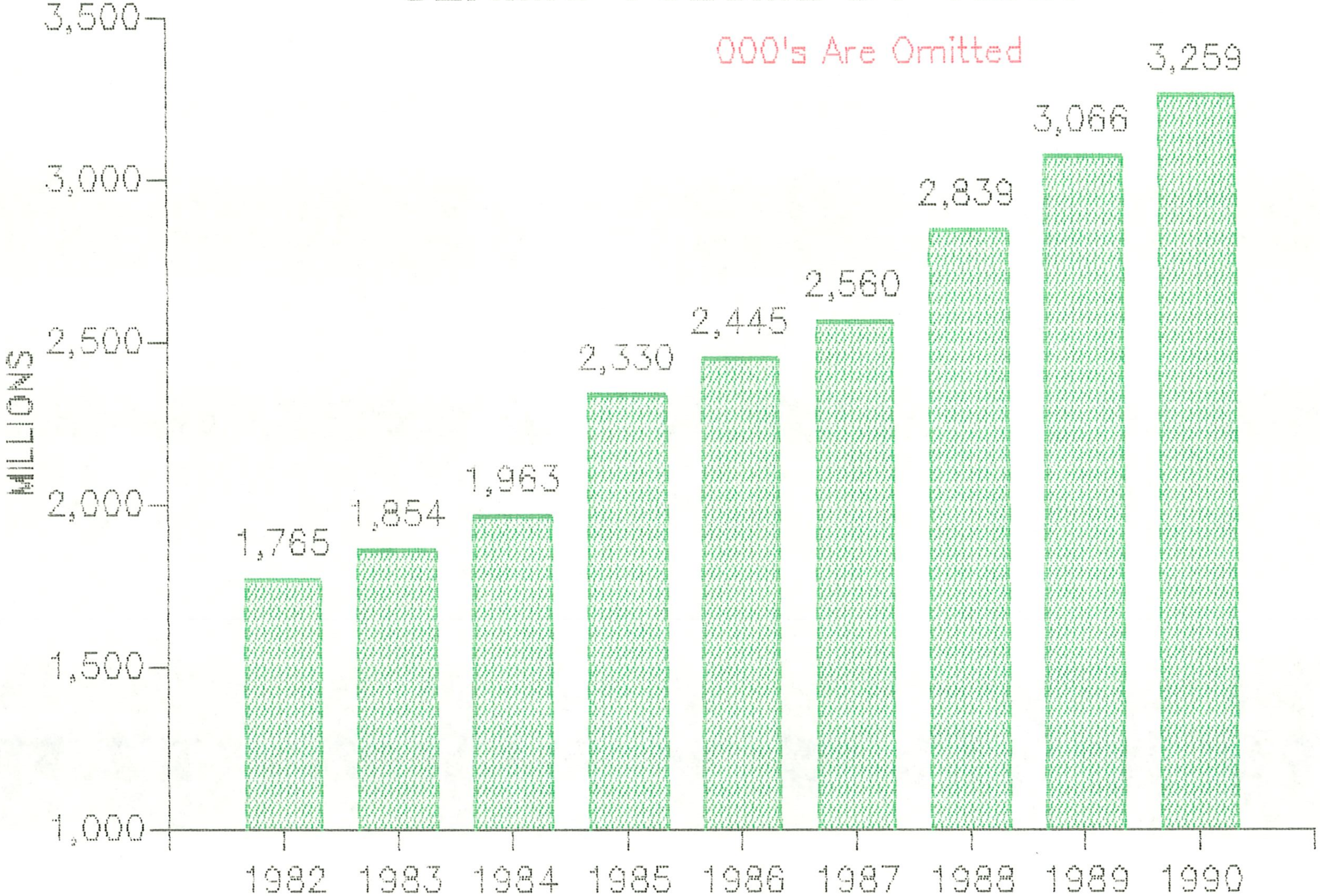
Note: Medicare statistics were used to demonstrate utilization trends due to the commonality of benefit package design for the population.

1-5

KANSAS MEDICARE B
BENEFIT PAYOUT BY YEAR

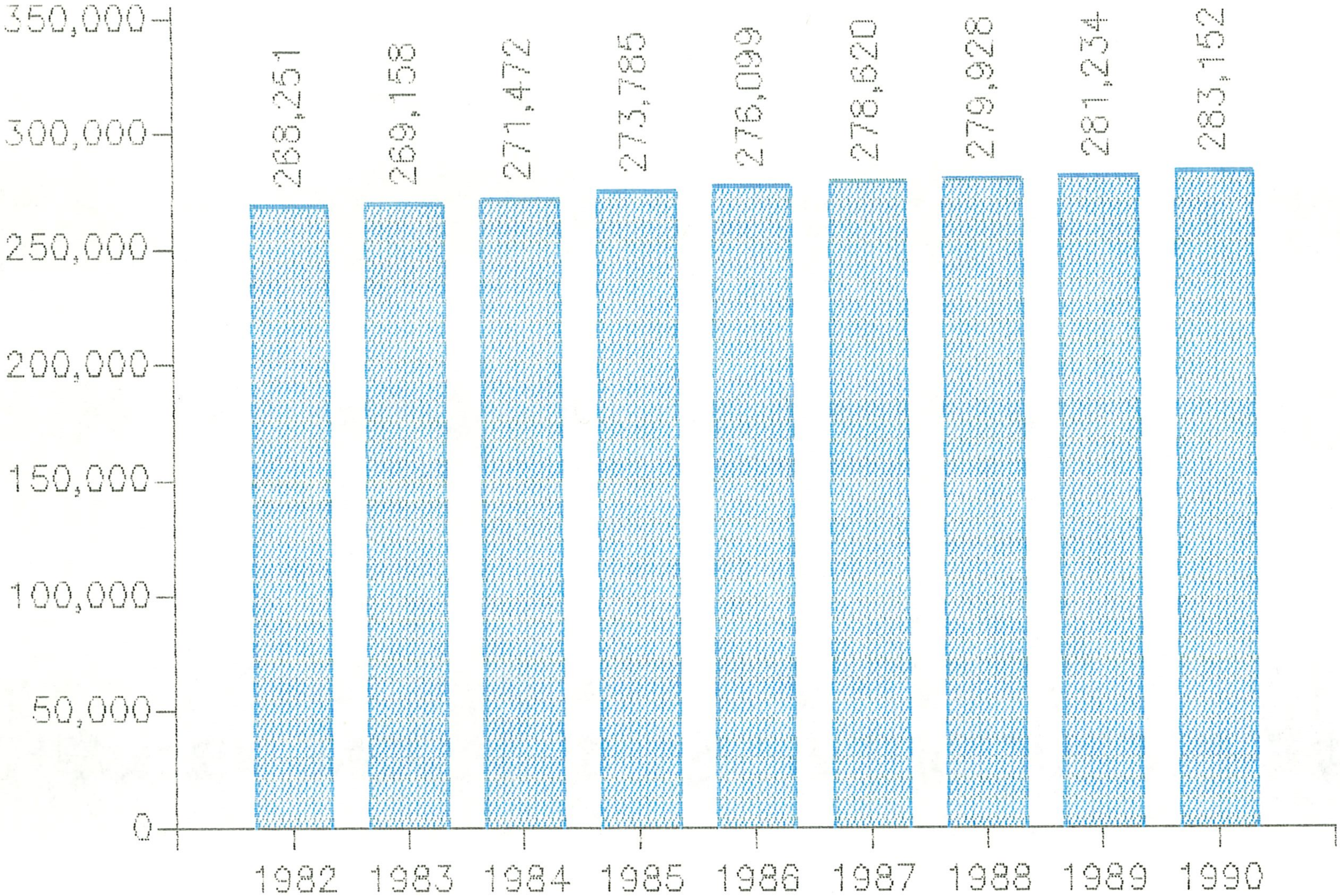


PHYSICIANS
KANSAS MEDICARE B
CLAIMS VOLUME BY YEAR



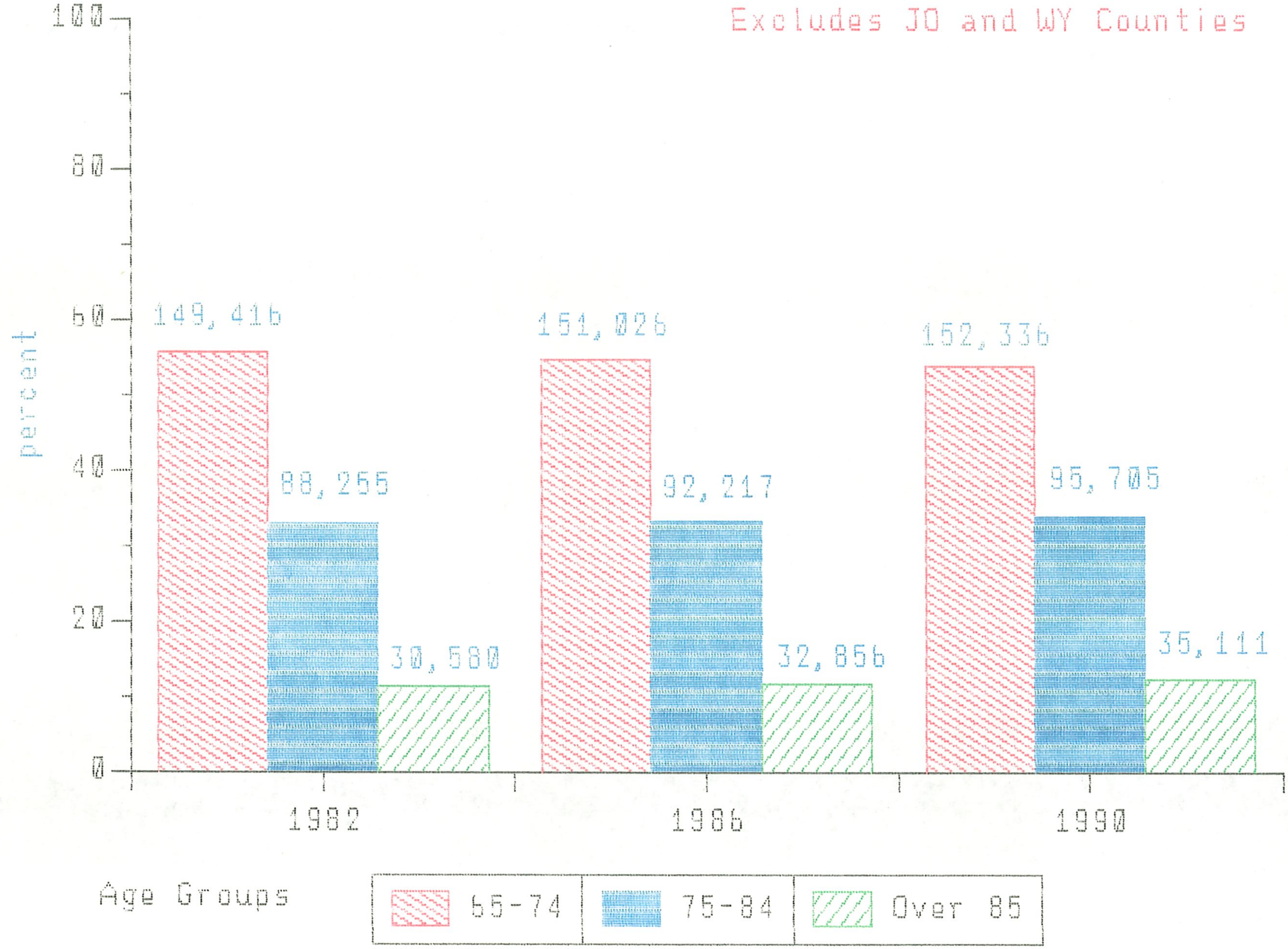
1-8

OVER AGE 65
MEDICARE BENEFICIARIES



AGING TRENDS FOR OVER 65 POPULATION
KANSAS

1-9



TO: Roy Ehrlich
Chairman, Senate Public Health and Welfare Committee

FROM: LewJene Schneider
Health Insurance Association of America

DATE: February 27, 1991

RE: Senate Bill 205

Mr. Chairman and Members of the Committee: My name is LewJene Schneider and I am a Legislative Representative for the Health Insurance Association of America (HIAA). HIAA is a health insurance trade association consisting of over 325 insurance companies that write over 85% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to S.B. 205 and its potential effect in the state of Kansas.

The HIAA shares the concerns of the Kansas Legislature, employers and consumers concerning the high cost of health care in the United States. Also, we share concern over the problem that small employers have in obtaining and retaining reasonable health care benefits and the obstacles the self-employed and those not eligible for group health insurance plans face in obtaining and retaining reasonable health care benefits at an affordable price.

I believe you all received a copy of the Canadian Health Care bulletin. I would bring to your attention that over the last 10 years per capita health care spending grew slightly faster in Canada than in the United States. The average annual increase was 4.28% in Canada, as compared to 3.93% in the U.S.

HIAA believes that this bill would not make significant

Senate P H&W
Attachment #2
2-28-91

2

contributions toward solving the initial problem, which is cost containment. We also acknowledge that there are existing gaps in health insurance coverage and believe there are possible solutions to these gaps. However, we do not believe this bill will fill those gaps.

Currently, as you all are aware, the House has introduced House Bill 2001, which addresses the eligibility of coverage under group policies and the rates of these policies. Assigned Risk Plans are also being discussed later this afternoon in the House Insurance Committee. Thus, the industry, the Insurance Commissioner and the consumers are well aware that this problem exists and are trying to find workable solutions. I believe these groups need an opportunity to determine the viability of these bills and to further determine if they can be successful before this legislation is passed.

Government financing of hospital and physician care in Canada did not happen over night. Conversely, it fully matured in 1971 after being initiated and developed gradually over a period of many years, beginning just after World War II.

On the surface the Canadian plan does sound like a cure-all. But there are reports of long waiting lists for surgeries such as coronary by-pass, hip replacement and cataract removal. The Canadian health care system suffers access problems and waiting lists at least for certain kinds of care in some parts of the country. Long waits for certain surgical and diagnostic procedures, along with preventive tests such as mammograms are common. Deaths have been reported among patients on waiting lists for heart surgery. Acknowledging that waiting lists for heart surgery are too long, at least two provinces have agreed to pay for Canadians to have their surgery performed at U.S. hospitals. To whom and where will we send our residents in need of surgery?

Is the Canadian system working? HIAA is not convinced that it is. Canada has almost 30% more hospital beds per 1,000 population that the United States, and those beds are more often full. There is a 81.5% occupancy in Canada versus 64.3% in the United States. Annual inpatient admission rates are only slightly higher in Canada, but average length of stay is dramatically longer in Canada, 52% longer. Therefore, the result is that total patient days per 1,000 populations are 63% higher in Canada.

Government control of hospital operating budgets and capital expansion plans also insure that new technology does **NOT** proliferate as rapidly or as extensively in Canada as in the United States. Currently the United States has more technological units per million inhabitants than does Canada, ranging from 1.2 times the number of organ transplantation units to 8 times the number of Magnetic Resonance Imaging (MRI) units.

In addition, Canadian physicians strive to maintain or increase total income in the face of fee freezes or limits by providing more services or at least billing for more services by separating services previously packaged together. Between 1971 and 1985, per capita utilization of physician services grew much more rapidly in Canada--67.8%, compared to 49.4% in the United States.

More significantly, utilization per physician over the same period rose a total of 25.1% in Canada, but only 7.0% in the United States. Not surprisingly, controlling increases in utilization of physician services has become a major issue for the Canadian health care system today.

The HIAA aggressively supports the development of federal catastrophic health insurance legislation which: (1) encourages, through strong tax incentives and disincentives, employers to provide, through the private sector, a minimum catastrophic benefit to all employees and their dependents; (2) provides increased tax incentives for individual to purchase such coverage; (3) provides for a pooling mechanism to guarantee the availability of that coverage to all Kansans; (4) provides for a minimum of federal regulation which, except for surveillance of compliance, avoids other intrusion of the federal government in the regulation of insurance; and (5) uses any government revenues only for the purchase of improved benefits for the poor and Medicare recipients.

Clearly, the Kansas Legislature must work to assure access to health care for all Kansans. Equally clearly, we must do a better job of containing health care cost increases while maintaining quality of care. But public insurance fashioned on the Canadian model does not seem to be an approach that would work well in Kansas. Instead, there would be substantial advantages in reforming health care by building on the strengths of our existing employer-based private system. Chief among these is flexibility in developing an innovative health financing structure that will meet society's demand for efficiently delivered, quality health care.

CONCLUSION

On behalf of my client, again let me thank you for allowing us the opportunity to appear before this Committee. It is our hope that these remarks will provide the Legislature a positive approach to the health insurance concerns that are being reviewed by the Legislature. We would ask the Committee to act disfavorably on S.B. 205.

Respectfully submitted,

LewJene Schneider
Legislative Representative
Health Insurance Association of America

ALDERSON, ALDERSON, MONTGOMERY & NEWBERY

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MEMORANDUM

TO : MEMBERS OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

FROM : ALAN F. ALDERSON, LEGISLATIVE COUNSEL FOR THE TOBACCO INSTITUTE

RE : SENATE BILL NO. 205

DATE : FEBRUARY 27, 1991

I am Alan Alderson, appearing on behalf of The Tobacco Institute, a National Association of Tobacco Product Manufacturers. The Tobacco Institute appears in opposition to Senate Bill No. 205. Specifically, The Tobacco Institute opposes the funding mechanism found in Section 17 of the Bill.

Our reading of Senate Bill 205 indicates that a surcharge equal to ten percent of the retail price of tobacco products is being levied on the sale at retail of cigarettes, cigars, snuff and other tobacco products under Article 33 of Chapter 79 of the Kansas Statutes Annotated. Although the money collected as surcharges on tobacco products and other tangible personal property is to be deposited in the state general fund, the bill also appears to require the Legislature to annually appropriate all of said funds derived from these surcharges to the Kansas health care trust fund, to be used for establishing prevention programs and the payment of health care providers. Therefore, we believe it would be appropriate to describe this legislation as earmarking the proceeds of a cigarette tax for health care.

Traditionally, those who favor earmarking excise taxes imposed on smoking argue that illnesses that have been statistically associated with smoking cause a disproportionate drain on government-financed health programs. But, in fact, there are no reliable data on the health care costs of smoking, nor convincing evidence that smokers do not already pay their fair share. Earmarking advocates say that this tax on smokers would be, in effect, a "user fee." How can it be called a user fee? A true user-fee method for funding health care, based upon those who actually use the system would cause blacks to pay more than whites and lower income groups to pay more than the wealthy. Is that how Kansas wants its tax policy to work?

Even if it were true that smokers <u>did</u> incur larger medical costs, why should they bear a disproportionate burden by paying an extra tax? Skiers, football players and the obese all voluntarily take risks. Ill health effects have been associated with consumption of dairy products, eggs, coffee, sugar and red meat. Imagine what would happen if the government slapped a health tax on every citizen who is not getting enough fiber, or who fails to exercise.

Senate P H&W
Attachment #3
2-28-91

Earmarking tobacco products taxes is not only an unfair tax policy, it is unwise tax policy. Earmarking is also unreliable. Taxing a shrinking base is bound to cause money to be taken from other worthy programs in the long run or raise taxes originally earmarked to pay for the taxes that the earmarking originally was intended to fund.

The approximately 541,000 Kansas residents who smoke have already been hit hard by a barrage of tax increases, including an 8 cent federal tax increase in 1983, 13 cents in State tax increase since 1983, a 4 cent federal tax increase in 1991 and an additional 4 cent federal tax increase in 1993. The Senate Assessment in Taxation Committee has already passed Senate Bill 61 which would add a 9 cent State tax increase -- which would result in a 34 cent per pack increase in the last eight years. The regressive impact of cigarette taxes is also especially harmful to minority groups and low income families.

Please also be aware that Kansas is in a vulnerable position with respect to cigarette taxes due to significant savings which would be available on most borders. A ten percent surcharge on the retail cost of a pack of cigarettes could, we assume, amount to an additional 15 cent per pack tax. This would leave a 26 cent per pack gap between the tax in Missouri and the tax in Kansas. There would be a savings of several hundred dollars per year for those who would purchase cigarettes in Missouri, and not in Kansas.

Finally, we believe the administration of the surcharge tax portions of this bill would be a nightmare, if not impossible. Under Section 17, the surcharge is said to be imposed on the sale at retail of cigarettes and other tobacco products while, at the same time, the bill says that the moneys are to be collected in the same manner and at the same times as such taxes are collected under law. Please be advised that cigarette taxes are collected on the wholesale transaction. The retail price of cigarettes is not regulated at that point and it would be an impossibility to compute the amount of tax that the wholesaler is required to collect.

Even if the surcharge was levied at the time the retail sale is made, it would appear that an entirely new mechanism would need to be created for the collection of that tax. It is also unclear as to whether the State and Federal taxes included within the "retail" price would be a part of the base for the surcharge. It is my general understanding that it would be unconstitutional to impose a state excise tax on a retail price which included a federal tax within its base. Therefore, the retailer would have to back out the federal tax to determine the appropriate tax base.

For all of the reasons given herein, we would urge you to defeat Senate Bill 205 or, in the alternative, that portion of the Bill which would impose the surcharge on cigarette and tobacco products.

HEIN AND EBERT, CHTD.
ATTORNEYS AT LAW
5845 S.W. 29th, Topeka, Kansas 66614
Telefax 913/273-9243
913/273-1441

Ronald R. Hein
William F. Ebert
Steven D. Rosel

**SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
TESTIMONY RE: SB 205**

**PRESENTED BY RONALD R. HEIN ON BEHALF OF
R. J. REYNOLDS TOBACCO USA
February 27, 1991**

Mr. Chairman, members of the committee:

My name is Ron Hein, and I am legislative counsel for R. J. Reynolds Tobacco.

On behalf of our customers who will pay this tax increase, we oppose SB 205. This is not a tax increase on tobacco and this is not a tax increase on tobacco companies. SB 205 is, pure and simple, a general tax increase on citizens in this state. According to the Tobacco Institute, approximately 29% of the adults will pay this tax increase.

At a time when the voters are begging their legislators not to have anymore tax increases, this direct tax increase on hundreds of thousands of Kansans is being considered.

You have already heard testimony today that a cigarette tax increase is a regressive tax, that hits the poor harder than anybody else. In addition to that, this tax is being paid by a minority of the people in order to fund a program that benefits all Kansans.

In addition, you have also heard testimony about what this tax will do on border sales. It is possible that you will be able to measure the lost cigarette tax collections resulting from an increase in the rate, but it is doubtful that you will be able to measure the lost sales tax revenue or gasoline tax revenue which results from persons purchasing tobacco products and at the same time, gasoline and other grocery articles across the state line. Do not be deceived that simply because you're increasing the rate of the tax that the state will necessarily collect more tax revenue.

In conclusion, although we may see numerous proposals to shift taxes from one revenue source to another for purposes of accomplishing property tax relief this year, this is a tax increase on 29% of the public. We hope that you will oppose SB 205, and hope that if you are desirous of funding this program to benefit the entire state of Kansas, that you will do so by appropriating sufficient revenues out of the State General Fund to do so.

Thank you very much for considering our views today and I would be happy to yield for any questions.

Senate P H&W
Attachment #4
2-28-91

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 Bank IV Tower One Townsite Plaza Topeka, KS 66603-3460 (913) 357-6321

A consolidation of the Kansas State Chamber of Commerce, Associated Industries of Kansas, Kansas Retail Council

SB 205 February 27, 1991

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Public Health and Welfare

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

I am Terry Leatherman. I am the Executive Director of the Kansas Industrial Council, a major division of the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to comment on SB 205, which strives to bring health care insurance to all Kansans.

> The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.
>
> KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.
>
> The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

Senate P H&W
Attachment # 5
2-28-91

KCCI cannot support SB 205 at this time. At the heart of the Kansas Chamber's opposition to the bill is the requirement for all Kansas employers to pay a health premium surcharge equal to eight percent of all wages paid to employees. It is a fundamental principle of the Kansas Chamber that health insurance is an employee benefit which employers provide at a level which they can afford, not a government mandate which employers must adhere to.

In addition to this fundamental belief, it is important to dispel the notion that "good employers provide health insurance to their workers, while bad employers ignore the needs of their employees by failing to provide an insurance program." The decision to provide health insurance is not based on philanthropy. It is a decision driven by employer size and economic health.

A year ago, KCCI surveyed its members on their insurance experience. Of the 423 members who responded to the survey, 92% indicated they offer a health insurance program to their employees. However, the response to that question changed drastically, when broken down by the size of the business.

* 100% of businesses with more than 100 employees offered insurance (94 of 94)
* 96% of businesses employing 25 to 100 employees offered insurance (129 of 134)
* 92% of businesses employing 10 to 25 employees offered insurance (98 of 107)
* 76% of businesses employing less than 10 employees offered insurance (67 of 88)

To require all employers to pay eight cents of every dollar in employee salaries to a statewide health care system would place a significant burden on small businesses who cannot afford to provide health care insurance to their employees.

KCCI is opposed to SB 205, but I do not want to walk away from this Committee and leave behind the impression Kansas business opposes the laudable goals of this legislation. A short hospital stay today costs thousands of dollars. Med-flation drives health insurance costs into double-digit increases annually. For the insured, spiraling costs causes tough decisions on what medical care to cover and what to delete. For the

400,000 uninsured Kansans, the medical care they receive depends on the charity of the medical community.

KCCI realizes developing any reform of the health care delivery system must include Kansas business. Of the Kansans who have health insurance, two-thirds receive their coverage through employer sponsored programs. Insurance costs are also increasingly becoming a major portion of a business' bottom line. Private health insurance plans cost $1,700 per employee/per year nationwide.

The authors of SB 205 understand the enormity of this social problem, but have devised a massive and costly solution. Their solutions shake the fundamental philosophies which medical providers, insurance companies, businesses and taxpayers have maintained for years.

Please do not pass SB 205. However, it is equally important to not forget about SB 205. KCCI looks forward to joining other organizations involved in the health care delivery process in working with the Legislature in this area. Hopefully, our combined efforts can develop the mechanism where all Kansans have access to the health care they desperately want and need.

Thank you for considering KCCI's position on this issue. I would be happy to attempt to answer any questions.

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

Testimony to Senate Public Health & Welfare Committee on SB 205 (statewide insurance program)

by James P. Schwartz Jr.
Consulting Director
February 27, 1991

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is 100 employers across Kansas who share concerns about the cost-effectiveness of healthcare purchased for our 350,000 Kansas employees and dependents.

The Kansas Employer Coalition on Health has a great deal of admiration for SB 205. Like many of you, we have gone through a lengthy process of grappling with these issues of healthcare cost and access. Many of the objectives of the bill, like providing universal insurance at a widely distributed and controlled cost, are aspirations we share with the authors of the bill.

The bill is elegantly crafted and well thought through. We admire the inclusion of financial risk sharing on the part of individuals through co-payments. We respect the two-tiered approach, reflecting both the care that every citizen has a right to expect and the care that might be considered above and beyond the basics. We admire the global budgeting for healthcare facilities and fee schedules for individual providers.

Yet, while we clearly support most of the aims of the bill, we basically feel that the bill goes needlessly far in placing the reins of the healthcare system into the hands of the public sector. The bill calls for the funding of basic healthcare for all Kansans through a single public entity. Most Kansas employers are uncomfortable with that kind of public authority over a sensitive human-service system like healthcare.

According to a recent national survey, over 90% of corporate executives believe the healthcare system of the future should continue to involve both the public and private sectors. And nearly three-fourths believe our health insurance system should continue to operate largely through employment-based plans. With the exception of union leaders, practically every other interest group echoed the same opinion. Our own survey of Kansas groups also found wide support for the principle of building on current structures to the maximum extent possible. That's not to say we hold out hope for piecemeal solutions. We

Senate P H&W
Attachment #6
2-27-91

6

agree with you that comprehensive reform is needed. We just think that other approaches emphasizing a stronger role for the private sector should be exhausted before embracing the public route described by SB 205. One such approach is outlined in a paper we've put out on this subject of healthcare system reform.

It seems clear to us that some kind of reform is needed — and soon. But more important than speed is the rightness of the choice we make. After all, we'll likely have to live with that choice for a long time. And when it comes to our health, we want to make the very best choice we possibly can. With that in mind, we suggest that the issue be made a priority item for interim study.

PREPARED STATEMENT OF THE
SMOKELESS TOBACCO COUNCIL, INC.
IN OPPOSITION TO SENATE BILL 205
February 27, 1991

Mr. Chairman, Members of the Committee:

My name is Bill Sneed and I am Legislative Counsel for the Smokeless Tobacco Council, Inc. The Smokeless Tobacco Council, Inc., an association of smokeless tobacco manufacturers with its headquarters in Washington, D.C., appreciates the opportunity to present testimony in opposition to Senate Bill 205. The Council represents the major domestic manufacturers of smokeless tobacco products in Kansas and throughout the nation. I have attached an exhibit to my remarks which lists the members of the Smokeless Tobacco Council.

Initially, let me unequivocally state that the Council and its various members support all of the various goals encompassed in S.B. 205. However, we submit that the tax proposal under consideration by this Committee, which is included as the funding mechanism for the goals, is neither fair nor an effective way of providing such funding.

FAIRNESS

Initially, it is important to point out the demographics of those consumers who use smokeless tobacco products. They are typically individuals between the ages of 20 and 35 years old, high school graduates, and retain jobs which are commonly referred to as blue collar occupations. Thus, it is imminently clear, as has been demonstrated by other opponents of the bill, that the proposed tax would be severely regressive in nature and affect those individuals with the least amount of financial ability to pay for such a tax.

Senate P H&W
Attachment #7
2-28-91

In this era of attempting to provide various types of tax relief to those Kansas citizens with the least amount of financial wherewithal, we contend approval of the proposed bill would go directly to those Kansas citizens whom the Legislature has been attempting to provide tax relief for during this session. In short, a tax on smokeless tobacco is a highly regressive tax because its burdens are concentrated on people with relatively low incomes.

ADDITIONAL TAXATION

I am sure the Committee is aware, but I would be remiss by not reminding the Committee of the substantial federal tax increase my client incurred effective January 1, 1991. By virtue of the new tax law, my client was assessed a 25% tax increase in federal taxes on January 1, 1991, and will pay an additional 25% increase on January 1, 1993.

This issue is compounded by the fact that smokeless tobacco products are currently double taxed. There is the current 10% state excise tax, and in addition, a state sales tax at the time of purchase is added to the already taxed product.

CROSS-OVER ISSUE

You will hear testimony today of the problems that occur due to the significant differences in state tax rates between the various states. Although you could argue that a slight tax rate increase versus a 10% tax rate in another state could lend only minor bootlegging of products, in our case it is even more dramatic. Currently the state of Missouri has NO tax on smokeless tobacco products. This is even more dramatic in that even in Jackson County in Missouri there is NO tax on smokeless tobacco products. Thus, we believe that any increase in the tax in Kansas will lead to a major loss in tax revenue.

Further, the impact extends well beyond the immediate impact on smokeless tobacco sales and tax revenues. Again, as has been testified to by other opponents, people who travel to buy smokeless tobacco will buy other things as well as long as they are making the trip. Thus, the cross-over effect is far reaching as it relates to sales tax revenues.

CONCLUSION

The Smokeless Tobacco Council opposes enactment of Senate Bill 205 because it believes such a proposed tax would be an extraordinarily heavy and punitive levy. Further, the burden of the tax would be shouldered predominately by citizens with comparatively low incomes, and despite the regressive and punitive character of the proposed tax, little contribution would be made to the State of Kansas.

We appreciate this opportunity to appear before the Committee today, and we will be happy to answer any questions.

Respectfully submitted,

William W. Sneed

William W. Sneed
Legislative Counsel
The Smokeless Tobacco Council, Inc.

A BRIEF OF S.B. 235 CONCERNING BOTTLED WATER

The sections of the bill provide that:

Section 1 defines different types of bottled water and various definitions pertaining to the bottling process;

Section 2 pertains to approved sources of water, as well as standards applying to bottled water as mandated by FDA regulations;

Section 3 pertains to the filtering, processing and packaging of bottled water (including mineral) as specified by the FDA Good Manufacturing Practice Regulations (GMP's);

Section 4 pertains to the compliance of plant operators--specifically the sampling and analysis of water derived from approved sources, as defined in Section 2;

Section 5 applies to the procedures concerning sampling and monitoring;

Section 6 concerns the labeling requirements of bottled water;

Section 7 defines exceptions to the bottled water regulations (such as bottled soft drinks); and

Section 8 defines maximum chemical allowances for bottled water (an extensive list is provided in the bill).

Essentially, the IBWA model code of regulations (i.e., S.B. 235) would accomplish the following:

1. Call for more stringent microbiological and chemical control standards...and that all bottled H_2O is subject to effective germicidal treatment by "ozonation", carbonation or other equivalent disinfection approved by the appropriate state or regulatory department.

2. Mandate bottled H_2O shall not be transported or stored in bulk tanks or processed or bottled through equipment or lines used for any non-food product, or which has passed milk, fruit juice or other food products likely to contribute nutrients for microbial growth.

3. Maximum level of five parts per billion of lead for bottled water - EPA imposed as a standard.

4. Regulations requiring more current and detailed inspections of bottling plants, sampling/testing of bottled H_2O products, specific definitions of the various types of H_2O listed on bottle labels, testing ford contaminants listed but not regulated by EPA and a general updating of FDA regulations as they relate to bottled H_2O.

5. Each plant and product undergo an unannounced annual plant inspection by an independent third-party inspection organization. (Consumer confidence/good tasting product.)

6. 12 states have adopted IBWA Model Code of Regulations. 19 are reviewing or are in process of adopting IBWA regulations.

Senate P H&W
Attachment #8
2-28-91

8

State of Kansas

Joan Finney, Governor

Department of Health and Environment
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Testimony presented to

Senate Public Health & Welfare Committee

by

The Kansas Department of Health and Environment

Senate Bill 235

For the past several years, public concern regarding microbiological and chemical contaminants in the food supply has increased dramatically. The current Kansas Department of Health and Environment regulatory program addresses adulteration, misbranding, and general sanitation aspects of bottled water manufacturing but does not mandate specific compliance with regard to product sampling and compliance with standards for contaminants. Federal requirements are applicable only to interstate products.

S. B. 235 incorporates recommendations of the International Bottled Water Association and CFRs adopted by the U.S. Food & Drug Administration. We do not currently have specific requirements comparable to those proposed by S. B. 235. However, as a matter of routine, we at the Kansas Department of Health and Environment promote the provisions of 21 CFR, Sections 103.35, 110 and 129 referenced in S. B. 235. During our inspection activities and consultations with new and potential water bottling firms, we have emphasized that compliance with such CFRs would provide a quality product permitted to be distributed in interstate commerce.

We at the Kansas Department of Health and Environment feel there are three issues needing clarification. First of all, the provisions of this bill require water sampling to be performed by qualified personnel. The bill does not address the basis for determining such qualifications. Secondly, there is no requirement for bottled water plant operators or water dealers to report non-compliance with regard to contaminants to the Secretary. We feel this is important with regard to product recalls and notifications to the consuming public. Last of all, there are no sanctions for non-compliance. The first two issues could be addressed through the Secretary's authority to adopt regulations necessary to administer and enforce this act.

Senate P H&W
Attachment #9
2-28-91

We at the Kansas Department of Health and Environment support favorable consideration of S.B. 235.

Testimony presented by: Stephen N. Paige
Director
Bureau of Environmental Health Services
February 28, 1991