Approved Jan. 22nd, 1992
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

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

1:30 /a.m./p.m. on January 16, , 1992 in room 423-S of the Capitol.

All members were present except:
Representative Robert Grant, excused

Committee staff present:
Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Chairperson Sader called the first meeting of the House Public Health and Welfare Committee to order welcoming all members and visitors.

Chairperson Sader introduced and congratulated Representative Wiard on his appointment as Vice-Chair to this Committee. She explained that Representative Theo Cribbs, former Vice-Chair, had retired and Representative Wiard had been appointed to take over that position.

Representative Cribbs had been a member of the House Public Health and Welfare Committee for many years, and he will be truly missed by all members of this Committee.

Chair noted the Representative appointed to replace Rep. Cribbs in this Committee is Representative Robert (Bob) Grant who was unable to attend today as he has also been assigned to the Claims Committee that meets today during this time frame. These changes announced are the only changes for the 1992 Session in the Public Health and Welfare Committee.

Chair requested Mr. Furse, Revisor, review the Committee Rules to members. (See Attachment No. 1). He detailed the rules on procedure, action, and the application of same.

Chair drew attention to (Attachment No. 2), the Objectives of members of this Committee stated in 1991. Chair then invited each member to review, give additions to, or changes in their previous comments on goals stated one year ago.

Most of the objectives were the same from a year ago, i.e., improving health care needs of the elderly, more affordable health care and insurance; curb duplication of services; look at the big picture of the health care and accessibility for all Kansans; long-term care for the frail and elderly; curb medicaid costs.

Chairperson Sader thanked members for their in-put on the Objectives for this Committee. We will take a look at the Big Picture on overall health care and reform and the component parts of this picture that many of you have spoken about today.

She requested from staff an overview on the Governor's Task Force Report on Health Care that ties in with objectives and the focus of members as expressed this date.

Ms. Correll drew attention to (Attachment No. 3) the Report from the Task Force on Health Care. It was noted the members of this Task Force are from the private sector. Ms. Correll highlighted the report and outlined findings on, i.e., Health Care Access; Costs; Government's role in assistance; Business response to it's role in assistance.

The Task Force attempted to outline critical issues facing the health care delivery system in Kansas and the United States. It challenges all Kansans to become active participants in helping to determine the delivery system for health care that will best serve all Kansans, and recommended the following:

Universal access to basic and preventive health care.
The cost of providing health/medical care should be controlled.
We should emphasize research on the effectiveness of current and future health care therapies and technologies.
Health care should be geared toward individual responsibility for wellness and prevention.

There is a need to foster a culture in which quality of life is balanced against heroic medical measures to extend life.

Ms. Correll highlighted the recommendations for study and change, i.e., state government take the lead in formulating health discussion, health care planning, and devise methods for controlling costs and ensuring access to comprehensive health care; plan expansion of existing resources without duplication; rural hospitals to see cooperative agreements; satellite clinics be established and mobile technology used to better serve rural areas; have one governmental entity be the purchaser of all health/medical goods and services; medicaid be expanded to cover at least 75% of population below federal poverty level; government, business, industry, and individuals contribute financially to the health care delivery system; a better balance of primary care physicians; significant financial enrichment program for training, locating and retaining primary care practitioners to serve underserved populations; use of nurse practitioners in underserved areas; reduce health care costs by use of high technology whenever effective; use of interactive video and remote consultations carried over telecommunications network when applicable without the expense of a full-time physician; health care issues handled by those with no financial interests in medical delivery system; review of regulation in delivery of medical services; review of single-payer system for medical billing; Insurance companies operate only on basis of community rating; managed care to prevent unnecessary services; review of mandated services; health insurers be prevented from withholding, limiting or canceling coverage on those individuals with serious or protracted illnesses; malpractice lawsuit climate be reviewed and changed where necessary; review of payment schedule of all medical care providers.

Chair noted this Governor's Task Force Report on Health Care is a handy tool if members are asked to speak to groups. It is very concise and informative.

Chair noted it is important for this Committee to understand what machinery is in place in Kansas, what is going on in Kansas to address the issues of access/cost/cost-shifting that every state and the Federal Government are dealing with. She has attended many conferences and meetings and is encouraged that our state is coming along perhaps further than most. Our problem is that many constituents and even some among us are not yet aware that this is happening. Chair noted, she believes it is important that members of our Committee know where we are at this point. New legislation to strengthen and implement goals discussed today will eventually come to this Committee for implementation.

The machinery that is in place has been enacted by statute. Chair gave background of composition of the Joint Committee on Health Care Decisions for the 1990's, and noted it has been working for one year.

Chair gave a brief explanation of the 403 Commission, i.e., it was derived from Senate Bill 403. The 403 Commission reports monthly to the Joint Committee on Health Care Decisions for the 1990's, and is charged with presenting a State plan for health care delivery by June 1994. The Chair of this Commission is Dr. Bill Roy.

Chair highlighted goals the Commission is working on. Some funding will be provided by the private sector. There are many decisions to be dealt with, but the plan is in motion. This will be an important mission, and the plan, when implemented will be referred to the Committee on Public Health and Welfare for consideration and action.

Rep. Praeger suggested members of Public Health/Welfare Committee write to their Congressmen and Senators in Washington D.C., to suggest that the Oregon plan be allowed. Perhaps another Resolution to Washington would be appropriate.

Chair thought it would be helpful for members to have a review of the 300% Cap on SSI and its Impact of the Division of Assets. Chair requested this briefing from staff.

Emalene Correll gave a briefing on 300% SSI Cap and its Impact of Division of Assets, detailing how the exemptions were created. She noted the main concern in 48 of 50 states is the Medicaid program. Medicaid costs are soaring and something has to be done to curb this rise in costs. Medikan needs to be reduced, but we are still working on that. The fastest growing program is the Long-Term Care program which accounts for 42% of the Medicaid budget. Home Community Based Services last year were 41% of the budget. The decision to cap the SSI benefits was explained in detail.

Ms. Correll explained that Federal law superceeds state law. We in Kansas passed a Division of Assets law that was almost immediately superceded by the Federal law. So the division of assets is still in effect, but through Federal law.

Ms. Correll noted a memo will be sent to all members with an explanation of the 300% SSI Cap.

Chair thanked Ms. Correll.

Chair adjourned the meeting at 3:08 p.m.

Note: (Attachment No.4) Objectives-Goals, 1992 was added later.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Jan. 16th, 1992

NAME	ORGANIZATION	ADDRESS
Lisa Getz	Wichita Hospitals	Wichita
[illegible]	KAOM	Topeka
Rita Williams	Ks Pharmaceutical Assn.	Topeka
Reyton Thompson	Rep	Bissen
Connie Cole	intern	Emporia
Kerry Townsend	Kansas Hospital Association	Lawrence
Tom Bell	"	Topeka
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
Marilyn Bradt	Kansans for Improvement of Nursing Homes	Lawrence
Kirby Davis	intern	Olathe
John Peterson	Ks Assn Prof Psychologists	
BOB GEERS	Assn for Retarded Citizens/Kansas	TOPEKA
David Hanzlick	KS Dental Assn	Topeka
Marty Kennedy	Budget	"
Wendy J. Roach	Intern - Wagnon	
Pam Ward	Bd of Healing Arts	
Larry Buening	Bd of Healing Arts	"
Richard Morrissey	KDHE	"

N. Furse

January 16, 1991

COMMITTEE RULES
House Committee on Public Health and Welfare

I. Procedures.

A. The chairperson will provide notice of meetings and an agenda or agenda information to committee members and others as provided by rules of the House of Representatives.

B. Items listed on the agenda will be brought before the committee in order of appearance on the agenda, except that discussion and action on any bill or resolution previously heard may occur at any time subsequent to the bill or resolution being heard when called for by the chairperson.

C. Except for unusual circumstances as determined by the chairperson, no bill or resolution shall be acted upon by the committee on the same day on which the bill or resolution is heard.

D. All conferees shall submit written testimony and shall provide 28 copies to the committee secretary at the time of appearance.

II. Committee Actions.

A. The chairperson will recognize members individually for discussion on any bill or resolution or other committee matter.

B. Amendments to bills and resolutions must be germane to the subject of the bill or resolution. The amendment must be relevant, appropriate and have some relation to or involve the same subject as the bill or resolution to be amended.

C. At the discretion of the chairperson, action on bills or resolutions may be taken by consensus of the committee unless a committee member objects to this procedure.

D. A motion to amend a motion to amend shall not be in order. No substitute motion shall be in order.

E. When any motion to amend a bill or resolution contains distinct propositions, the chairperson at the request of any member of the committee shall divide the question.

F. A motion to "take from the table" shall be in order only when such item is on the agenda or is taken up by the chairperson. A motion to take from the table may be adopted by the affirmative vote of a majority of the members present at any called meeting of the committee.

III. Adjournment.

Adjournment of the committee shall be upon the motion of the chairperson.

IV. Robert's Rules -- Application.

In any case where the rules of the House, the joint rules of the Senate and House or the rules of this committee do not apply, Robert's Rules of Order, Newly Revised (copyright 1981), shall govern.

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1-16-92
Attm #1.

BJECTIVES OF COMMITTEE MEMBERS - 1991

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Ann Cozine:==

We will need to find ways to provide health care that meets the needs of clients better, within the budget that we have.

Alex Scott:

That is well said, I would add very little to that. We will need to be able to predict spending so that we can get the best for the dollars we have. We will need to concentrate more on prevention of problems. Birth control devices and things of that kind.

Ruth Ann Hackler:

Concerns are pretty much set out in paragraph 2 of minutes on January 16th. She is concerned about preventive care, what happens to children in the "system".

Galen Weiland:

He is concerned with medical insurance made available to nearly everyone somehow---affordable to nearly everyone, even if it is where they buy into a plan with a physician to the ability of applicable payment for health care.

Joann Flower:
She certainly agrees with all that had been said before her. She also would like a focus on keeping the elderly in their homes. This is getting bang for the buck, it is for the benefit emotionally of the elderly, can be done through the existing local Health Departments in many cases. This is a special interest of hers, as well as prenatal care and care of children in the state.

Tom Bishop:
Rep. Flower just stole his speach. Long term care for the elderly is vital, especially in home services that allows the elderly to stay in their own homes reducing Institutional bias in our state.

Rep. Amos:
Rep. Sader has the advantage of hearings from SRS Task Force. But he knows of some concerns, i.e., duplication of services. In some cases there may be people using services that are not entitled to the Kansas dollars. He would like to find ways of correcting duplication so that we could get better use of the dollars being provided. There is such a challange to meet with all the on-going programs.

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Attm #2
1-16-92

Dorothy Flottman:-
Has concerns about housing the mentally retarded. The downsize of housing the mentally retarded has been brought out in a report yesterday in committee and the plans for the Federal Government not funding any Institution with over 15 residents. This would eliminate funding from the Feds in all three of our States larger Institutions. She doesn't object to placing these people in Community Based Homes, but she does feel there still needs to be a choice. There are many many profoundly mentally retarded and physically handicapped and many are concerned this type of patient might night be properly cared for in a Community Based setting. She would like Public Health and Welfare and perhaps the Appropriations Committee to realize this certain population that would not be suitable to go into a Community Setting. If the Federal Government will not help fund these programs, we may have to see about total State funding. She noted Winfield Hospital is the only hospital that takes babies born to mothers who are on drugs. She talked about this sad situation. The condition of these babies is unbelievable.

Rep. Tom Love:-
He wanted to focus on public assistance when he asked to be assigned to this committee. Now that he hears all these other concerns. He had a question that has never made sense to him, ---people who work and do not receive a very large salary, do not have access to health care, while people who do not work, (or work very little) seem to be eligible for all types of health care services. This should be examined.

Sandy Praeger:The hope would be that there would no longer be any medically indigent. Affordable, quality health care is of concern to her. Interested in the local Youth Authority and a couple of projects being proposed, and funding of those things. Often a teenager needs only some counseling, not being housed in a $60. per day facility. She thinks a better job can be done and it will save money in the long run. She is also very interested in Long term care for the elderly.

Susan Wagle:She has been a special education teacher, has worked with the underprivileged. She would like to see more efficient health care systems, noting complaints of some in nursing homes where many unnecessary tests had been ordered. This alone would save dollars.

Steve Wiard:He agrees with all said so far. He would like to see committee focus on being more pro-active rather than being re-active. It is appauling that 20 percent of Kansas children live in poverty. We have to face reality however, so perhaps we need to re-prioritize more than we have. We keep waiting for the Federal Government. We keep modeling Oregon, and they are on the cutting edge. Why can't Kansas be the state that is modeled? He quoted someone as saying we have a sick-care Society, not a health-care Society. We need to focus on preventive care.

Attach #2
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1991
Committee objectives

Representative
Melvin Neufeld:

He has no particular objective, he is here to help the Rural Health Care System to the best of his ability. This is his focus.

Eloise Lynch:

She too is concerned with Rural Health Care. As a Committee member, she feels the importance of looking at the present Kansas Statutes to see what the present situations are, and what is possible for the future. Let's do look around at Oregon and see what is being done.

Rep. Carmody:

He agrees all said previously is obviously needed. However, if we view all these services with a divide and expand viewpoint, we need to meld the two systems, i.e., those who can afford and have insurance for health care, and those who cannot afford and do not have. Let's look at the entire problem.

Rep. White:

A number of issues concern him, i.e., quality insurance. Do we <u>really</u> have quality insurance? There is a great deal of time spent maintaining charts, doing paper work. Long term care is a concern, as is rural health care. The next two years, babies born in the far reaching rural areas of the state will be born in the home, or in the car on the way to the hospital. He sees advantages to Community Home Based facilities for the mentally retarded. Would like to see satellite health care facilities for services. Would like to see some basic health care being provided to those in outlying rural communities.

Rep. Samuelson:

Amen, Amen, Amen.

Rep. Sader:

She thanked all members for their thoughtful and perceptive analysis of what needs to be done. She noted she hopes many of these objectives can be reached, and hopes the Committee can work together to reach these challanges. She noted there could hopefully be updates on these objectives as we proceed in 1992 Session.

Approved
Attm. 2
Pg 3,
1-16-

KANSAS

November, 1991

CREATING TOMORROW IN HEALTH CARE

A special report by the Governor's Task Force on Health Care

PH+W
1-16-92
Attn #3

STATE OF KANSAS

OFFICE OF THE GOVERNOR

JOAN FINNEY, *Governor*
State Capitol, 2nd Floor
Topeka, KS 66612-1590

913-296-3232
1-800-432-2487
TDD# 1-800-992-0152
FAX# (913) 296-7973

Dear Fellow Kansan:

During my career in state government, I've grown increasingly concerned about the ever rising costs of health care in Kansas and the United States. The rising costs are leaving more and more Kansans unable to afford even basic health care.

Now, as your Governor, I'm in a position to guide Kansas toward meaningful health care reform. The problems are highly complex, but if we all work together they can be solved. The recommendations of The Task Force on Health Care represent a sturdy foundation upon which to build.

I wholeheartedly support the recommendations outlined by this Task Force and ask your help in proceeding with the study and implementation of these recommendations.

Sincerely yours,

Joan Finney

Joan Finney

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pg 2 & 25

GOVERNOR'S TASK FORCE ON HEALTH CARE

As part of Governor Joan Finney's "Creating Tomorrow" strategy for the future of Kansas, The Governor's Task Force on Health Care was formed in February 1991 to examine and understand the issues facing the delivery of health care in Kansas and the United States, and to provide an overview of the issues which will shape the future of health care in this state.

This document represents the initial steps of this Task Force in providing background information and possible plans of action to attain a strong health care delivery system for the future of Kansas. This document represents a consensus view related to the status of the health care delivery system in Kansas, as well as across the country. The recommendations for study and change are suggestive of the topics which need further attention. While individual members place varying degrees of importance on each recommendation, the consensus is that all items are significant and deserve study and action. Some of these items may be implemented quickly, while others will require further study and planning.

It is the hope of this Task Force that these recommendations will be carefully considered by the Legislature as laws are enacted that will lay the foundation for creating a tomorrow in health care that will equitably serve all Kansans.

TASK FORCE MEMBERS

Ed Bruske	Kansas Chamber of Commerce and Industry
Jim Callaway	Southwestern Bell Telephone
Duane Dyer	Wesley Foundation
Bob Harder	Former Secretary, Social and Rehabilitation Services
Dr. Jane Henney	University of Kansas Medical Center
Patricia Hurley	The Marian Clinic
Dr. Stanley Z. Koplik	Kansas Board of Regents
Dr. Roy Menninger	Menninger Foundation
Dr. Bill Roy, Sr.	Physician and former Congressman

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ACKNOWLEDGMENTS

For their invaluable assistance in compiling information and editing this report, the Task Force wishes to thank:

Caryl Clanton	Social and Rehabilitation Services
Terry Diebolt	Southwestern Bell Telephone
Terry Leatherman	Kansas Chamber of Commerce and Industry

The Task Force also wishes to thank Southwestern Bell Telephone for funding the production of this Special Report.

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CREATING TOMORROW IN HEALTH CARE

INTRODUCTION

The skyrocketing cost of health care is rapidly becoming recognized as the most critical issue facing citizens, businesses and lawmakers in the United States and Kansas.

The cost of health care has risen faster than general inflation every year for more than two decades. Because of the rising cost, fewer and fewer people have access to health care.

For the nation's governors, the need for health care reform topped the agenda at their annual conference, held in August, 1991, in Seattle. Many governors are seeking solutions as health costs consume increasing shares of state budgets. The governors agreed that health care reform needs to occur on the state level.

Kansans responding to a Kansas State University survey titled, "The 1991 Future of Kansas Survey", rated health care second only to education as the area most deserving increased governmental support.

Both Democrats and Republicans are reaching agreement that something must be done about the health care delivery system and it needs to be done soon.

Those of us fortunate enough to have health insurance coverage may be reluctant to believe that the health care delivery system is in need of major reform. But, the issue of providing affordable health care coverage for the citizens of our nation and state is an issue for everyone.

A course of action needs to be decided upon, adopted and implemented on state and national levels. While many people agree on basic principles of health care reform, that agreement has not sparked concrete action resulting in changes to the health care delivery system.

There is a need to go beyond general agreement about principles. An action model geared to change needs to be formulated and intensely reviewed. That action model should be built upon the basic premise that all Kansans and all Americans should have access to affordable, preventive and basic health care.

This document will highlight critical points in the health care discussion. It will provide an overview of the issue. It will suggest ideas and concepts to be discussed. Hopefully, it will trigger more discussion as to the need for accessible and affordable health care.

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THE PROBLEM: COST AND ACCESS

HEALTH CARE COSTS

In general, the rise in health care costs has been caused by increased demand for health care as a result of people's increased awareness of health care services; society's epidemics of poverty, violence, drugs, AIDS and teenage pregnancy; aging of the population and the removal of the cost barrier for many by third-party payers.

Also contributing to the rising costs are an increasing number of physicians, increasing capital expenditures, duplication of resources and the implementation of therapies, tests and technologies that are often not subjected to effectiveness research.

American consumers have come to expect medical miracles to be performed with the latest technology and science. This high technology has saved the lives of thousands of people in the United States. But, even with the highest technology available in its medical bag, the United States does not have the healthiest people in the world.

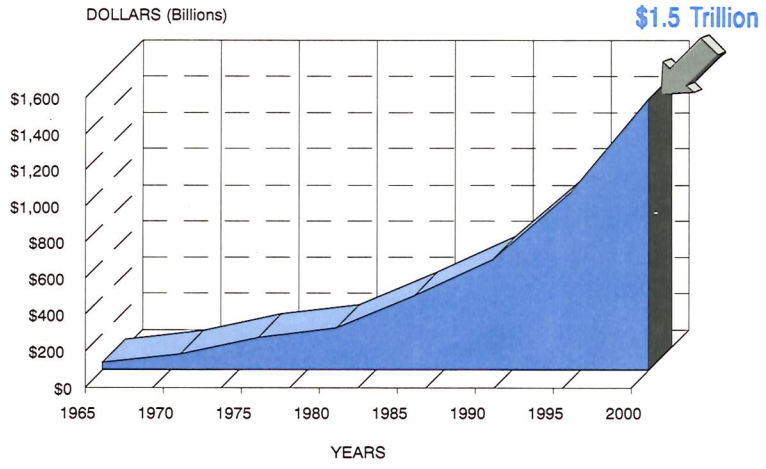
- Americans will spend an estimated $700 billion this year on health care. This is 8 percent more than in 1990 and 144 percent more than was spent in 1980.

- Left unchecked, health care spending is projected to reach $1.5 trillion by the year 2000.

- Health care in one form or another accounts for 12 percent of the gross national product.

- CEOs of major corporations and union representatives alike have proclaimed health care as the No. 1 challenge facing American business.

TOTAL HEALTH CARE SPENDING



Source: Health Care Financing Administration

- It has been estimated that employer health benefit costs consume 26 cents of every dollar of profit.

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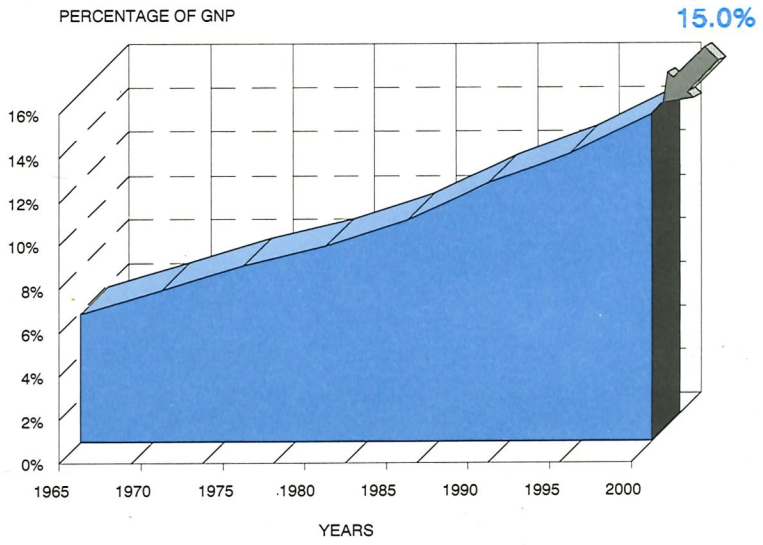
- 1990 marks the third consecutive year of severe increases in medical costs to businesses. Total health plan costs rose from an average of $2,748 per employee in 1989 to $3,217 in 1990.

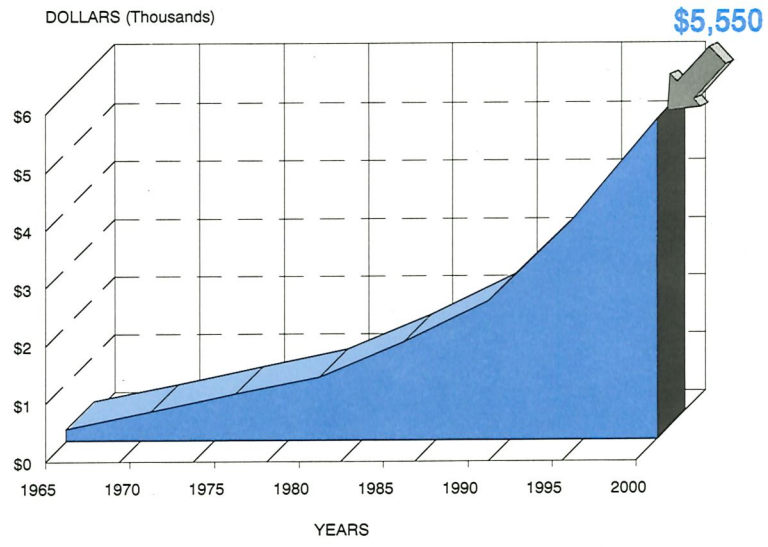
- Large and small business owners are increasingly concerned as the soaring health care costs affect their competitive edge in domestic and world markets.

HEALTH CARE'S GROWING BITE OF THE ECONOMY



Source: Health Care Financing Administration

HEALTH COSTS PER PERSON



Source: Health Care Financing Administration

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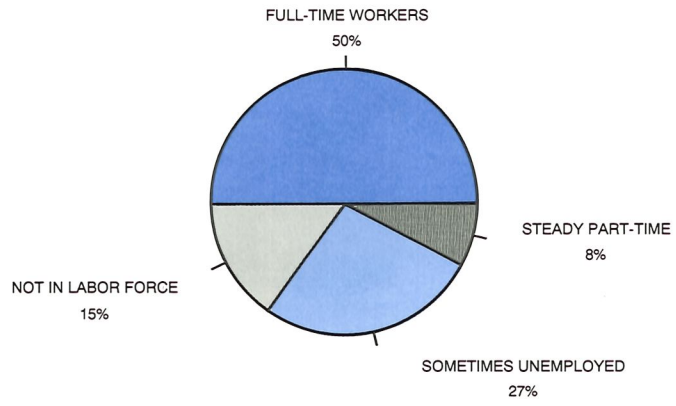
HEALTH CARE ACCESS

Despite all of the public, business and personal spending on health care, millions of Americans lack health insurance and, as a result, lack access to adequate health care.

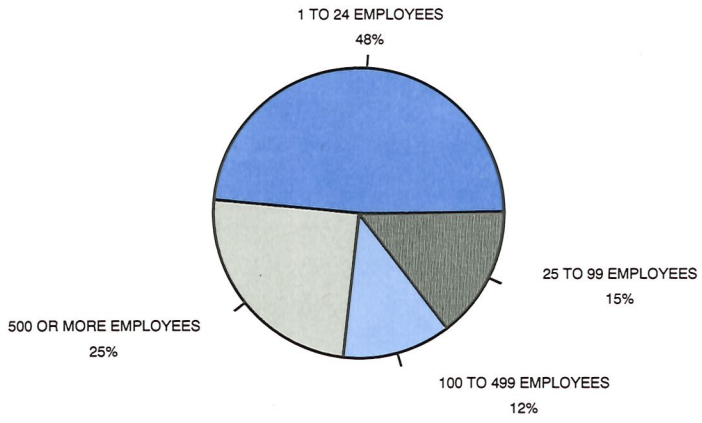
- Statistics show that up to 37 million Americans have no health insurance.
- Another 50 million are underinsured.
- Of the 37 million lacking health insurance, 50 percent have full-time jobs.
- Children are especially likely to be uninsured.
- An estimated 40 percent of agricultural workers and their families have no health insurance coverage.
- Forty-six percent of rural small businesses do not sponsor health insurance, compared with 28 percent of small businesses in urban areas.
- Rural Americans and rural Kansans also lack access to health care because doctors choose to practice in metropolitan areas.

UNINSURED AMERICANS

Who is uninsured...



...and where they work.



Source: Employee Benefits Research Institute, Small Business Administration

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"We have gotten to the point where everybody is scared," said Robert J. Blendon, an expert on public opinion and health policy and a professor at the Harvard School of Public Health. "Insurance costs are doubling every seven years and what employers are doing to contain costs, principally, is cutting back benefits," Blendon said. "Working people are already paying more for less coverage, and they know that in the next negotiation, the company will take back more benefits."

HIGH-RISK GROUPS

There are certain groups of Kansans, due primarily to economic and age factors, who are at a higher risk of lacking access to health care and health insurance. The general public also feels at risk of losing access to health care and health insurance due to increasing costs, limited providers, lack of planning and coordination and lack of emphasis on preventive and primary care.

The information regarding the following high-risk groups was taken from "The Medical Indigency Crisis in Kansas", a report by the Kansas Department of Health and Environment, July, 1986.

Elderly:

According to a study commissioned by the Kansas Department on Aging in 1979 and 1980 (latest study available), approximately 11 percent of all Kansans who are between the ages of 60 and 64 (11,663 at the time) had no health insurance and were not eligible for Medicare.

Medicare, which provides basic health care coverage to people 65 and older, often falls short of what is needed to pay the bills.

Roughly one-third of the average American's lifetime health expenditures occur in the last year of life, half of that in the final two months.

Children:

In 1979, 11.4 percent of Kansas children lived in families below the poverty level. This number increased to 14.2 percent by 1989. Due to economic considerations, most of these children lack access to adequate health care.

Homeless:

The number of homeless in Kansas is difficult to determine, but it has been estimated from as low as 5,000 to as high as 32,000. Virtually all lack adequate health care.

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Afro-Americans:

Afro-Americans represent from 5 to 10 percent of the total population in Kansas, however, as much as 25 percent of the persons eligible for medical assistance are Afro-American.

Twice as many Afro-American children than White children live in poverty. The percentage of low birth weight babies of Afro-Americans is more than double that of Whites. In infant mortality, the rate of Afro-Americans is more than double the rate of Whites.

Women:

Women between the ages of 45 and 65 represent another group lacking adequate access to health care. In this group, a number of women are either not employed or work part-time in low-paying jobs that offer no health benefits.

Many women also depend upon an employed spouse for access to medical care. If something happens to the spouse, they are left without medical coverage.

Working Poor:

Although they may be employed at least part-time, a number of Kansans still fall below the poverty level and qualify for state aid. Unfortunately, that aid (General Assistance and General Assistance-Medical) is being reduced, cutting off many from benefits. In Kansas, working poor receiving General Assistance has been reduced from a high of 18,000 persons to present coverage of 7,000.

Migrant and Seasonal Farm Workers:

There are an estimated 5,000 to 8,000 migrant farm laborers in Kansas who lack health services. They most often lack adequate housing and live in areas where public transportation and emergency assistance are nearly non-existent.

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GOVERNMENT ASSISTANCE IS FALLING BEHIND

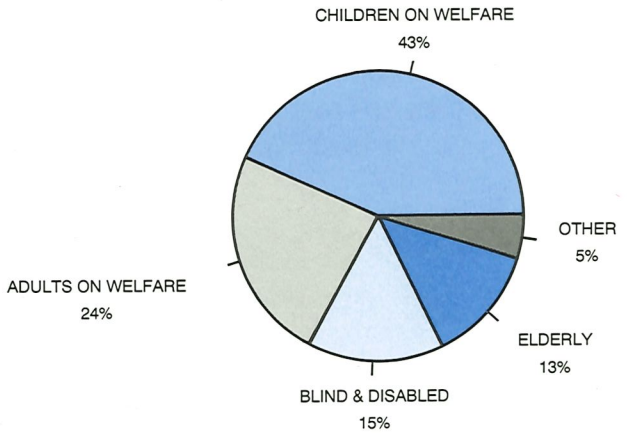
The price of health is a direct and growing worry for federal, state and local governments, which must devote an increasing share of their strained budgets to paying for health care. More than 40 percent of the nation's health bills are now covered by government programs.

A continually growing number of poor Americans are requiring Medicaid benefits. In 1989, 23.5 million Americans received Medicaid services. By comparison, in 1972, 17.6 million received Medicaid benefits.

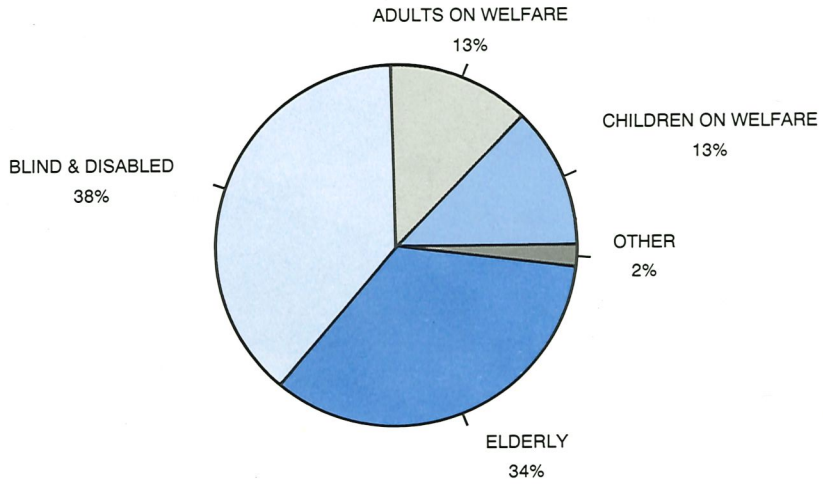
According to a New York Times health care series, published in April, 1991, Medicaid provides health insurance for the poorest families. However, Medicaid covers less than half of those below the poverty line nationwide. In most cases, a family of three must have a yearly income less than $7,000 to qualify for the program.

MEDICAID

Who receives Medicaid...



...and how much they receive.



Source: Congressional Quarterly, May 18, 1991

Overall federal and state spending on Medicaid continues to increase at an alarming rate. In 1972, the federal cost of Medicaid was $6.3 billion and in 1989, the federal cost was $54.5 billion. Federal cost for 1992 is expected to reach $60 billion, which will represent almost a 900 percent increase in 18 years. Despite the increasing spending, fewer and fewer services are being provided for those in need.

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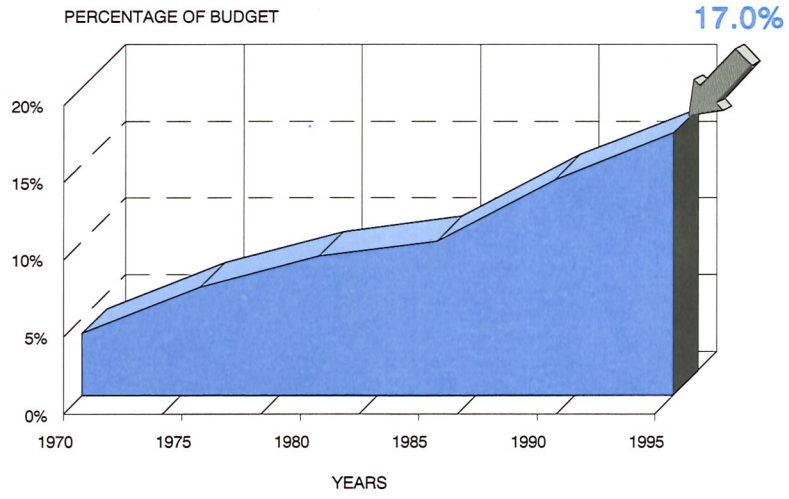
States spend approximately $25 billion a year to match federal Medicaid funds (half the total cost). And, state Medicaid expenses also are rising rapidly — 107 percent from 1980 to 1988. During this same period the Consumer Price Index rose by only 44 percent.

As the overall costs increase, the federal portion has dwindled. A decade ago federal money represented about 25 percent of state funds for all government services. The federal portion now represents about 17 percent of state funds.

The state response to controlling health care costs has been to simply limit reimbursements, restrict the scope of service and limit the size of the groups eligible for assistance. These strategies are restrictive and not geared toward solving the problem of making health care available to all Kansans.

MEDICAID'S SHARE OF STATE BUDGETS



Source: Congressional Quarterly, February 16, 1991

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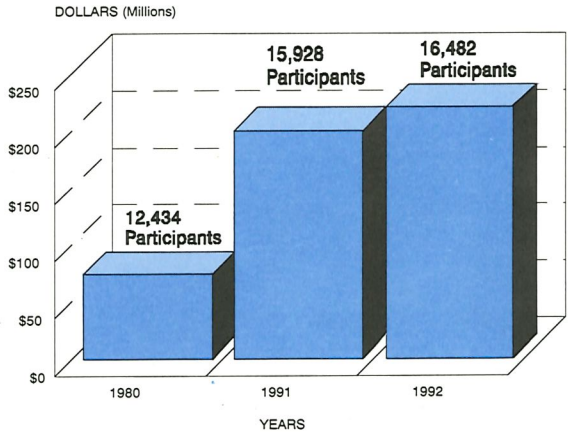
The following are samples of fees for medical services in Kansas and the amount Medicaid will pay:

- The average charge for a brief office visit to a Kansas doctor is $28. The state will reimburse $15.
- The average charge for an appendectomy is $750. The state will reimburse $268.
- Cataract surgery averages $1,900 in Kansas. The state will reimburse $750.

ADULT CARE HOME AND IN-HOME CARE SPENDING

KANSAS MEDICAID

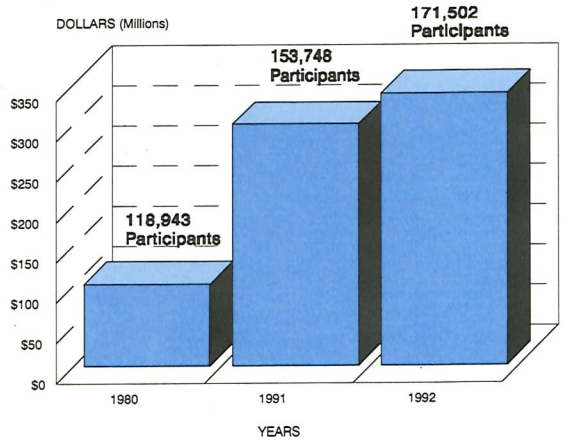


Source: Kansas Department of Social and Rehabilitation Services, February 11, 1991

Kansas medical spending for adults in care homes and in-home care totaled $73.9 million in 1980. That number is projected to grow to $220 million by 1992. *(not adjusted for inflation)*

MEDICAL CARE SERVICES SPENDING

KANSAS MEDICAID



Source: Kansas Department of Social and Rehabilitation Services, February 11, 1991

Medical spending for all other medical services in Kansas totaled $102.5 million in 1980. That amount is expected to climb to $338 million by 1992. *(not adjusted for inflation)*

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A BUSINESS RESPONSE

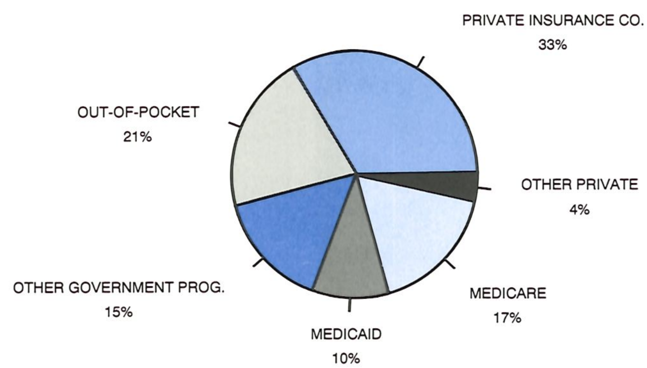
As health care costs have risen, many businesses, especially small businesses, have responded by cutting or eliminating health insurance benefits for workers.

Larger companies that have traditionally provided health insurance benefits have sought means of controlling costs, while retaining most benefits.

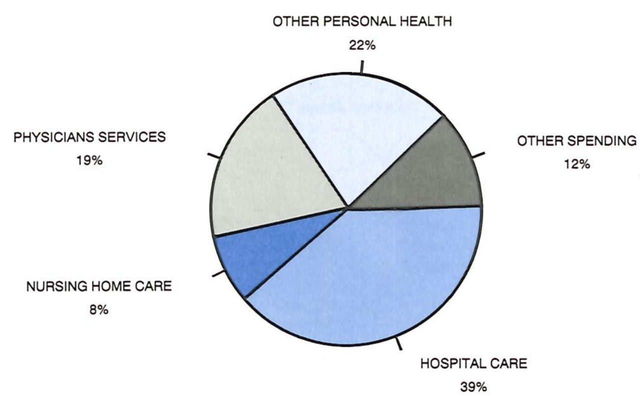
One such company, which operates in Kansas, was one of the first businesses in the nation to develop a managed-care approach to controlling rapidly increasing costs.

THE NATION'S HEALTH DOLLAR

Where it came from...



...and where it went.



Source: Health Care Financing Association, 1989 Study

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Southwestern Bell Corporation: Managed Care

Southwestern Bell Corporation, an international telecommunications corporation based in St. Louis, introduced a managed-care approach to health insurance in 1987.

Known as CustomCare, the plan was one of the first managed-care approaches in the nation by a major employer. CustomCare has since become a model for corporate health insurance plans.

Southwestern Bell sought the new plan for its 67,000 employees and 26,000 retirees following an analysis that showed health benefit spending had jumped 217 percent from 1979 to 1985. In 1985 the company spent $161 million on health benefits.

According to Southwestern Bell, CustomCare works because it blends the best features of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and indemnity plans.

From HMOs came CustomCare's pre-certification, utilization review and a wellness focus; from PPOs, negotiated provider discounts; and from traditional indemnity plans, flexibility and freedom of choice.

The Prudential Insurance Company, which administers the plan, created local networks of doctors, hospitals and other providers in the 13 major metropolitan areas in which 65 percent of SBC's employees and retirees live.

A primary care physician acts as a gatekeeper, and office visits are covered at 100 percent after a $10 copayment is met by the patient. Claims, pre-certification, second surgical opinions and utilization review are all handled by the primary care doctor. Employees may use non-network doctors if they pay a front-end deductible and a 20 percent copayment.

SBC's integrated managed-care approach is working. The company reports that from 1987 to 1988 the per person claim cost increase was 12 percent, compared with the national average of 18 to 20 percent. The increase from 1988 to 1989 was 7 percent, while the national average that year was 20 to 24 percent. Employee response to CustomCare has been favorable, with 82 percent "thinking highly" of the care received.

Kansas State Employee Plan: Co-insurance

In the late 1980s, the State Health Care Commission began to restructure the state employee health insurance plan following repeated annual increases in health care benefit costs of 10, 15, 20, and even 47 percent.

The state moved to subsidize not only the employee premium, but the family premium as well. The plan also called for the employees to share a greater portion of the costs.

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Blue Cross and Blue Shield's Blue Select plan became the major coverage plan. The plan design includes the following:

- The primary care program functions with no deductible.

- Benefits are paid at 80 percent of covered services. The employee is responsible for the other 20 percent to a maximum payment of $500 per person and $1,000 per family.

- After the coinsurance is met, the program will pay 100 percent of covered services for the balance of the benefit year.

- Inpatient hospital coverage is provided on the basis of $50 per day, to an annual maximum payment of $250 per person and $500 per family.

- In-area emergency room coverage requires a $25 copayment.

- All non-emergency admissions require pre-admission certification.

While these changes are helping to control the rate of increase in expense, the State plans to expand further the use of managed care in its health benefit plan to achieve further cost control.

Each of the above examples illustrates an effort at cost containment. In these strategies there is the move to managed care and a variety of reviews.

While such efforts frequently result in a shifting of more of the cost to individual employees, SBC's CustomCare has slightly lowered costs for employees who utilize its network. While each approach is helpful in containing costs for both entities (SBC and the State of Kansas), neither approach has a direct bearing on the issues of access and costs to the general population.

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A HEALTH CARE STRATEGY

The Task Force has attempted to outline the critical issues facing the health care delivery system in Kansas and the United States. The intent of the Task Force is to stimulate discussion among Kansans that will lead to solutions to these problems and will result in providing health care to a greater number of persons at reasonable costs.

The Task Force challenges all Kansans to become active participants in helping to determine the health delivery system that will best serve all Kansans.

The Task Force recommends the following basic principles become the foundation for building an adequate health care delivery system in Kansas:

- **There should be universal access to basic and preventive health care.**
- **The cost of providing health/medical care should be controlled.**
- **We should emphasize research on the effectiveness of current and future health care therapies and technologies.**
- **Health care should be geared toward individual responsibility for wellness and prevention.**
- **There is a need to foster a culture in which quality of life is balanced against heroic medical measures to extend life.**

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RECOMMENDATIONS FOR STUDY AND CHANGE

The Task Force strongly recommends:

- State government take the lead in formulating health discussion, health care planning and devising methods for controlling costs and ensuring access to comprehensive health care.

- Careful planning of medical services and facilities to expand the reach of existing resources without duplication or unnecessary increase in costs.

- Rural hospitals seek cooperative agreements, satellite clinics be established and mobile technology be used to better serve rural Kansans.

- State government leverage the dollars it spends on medical care by having one governmental entity be the purchaser of all health and medical goods and services.

- Medicaid be expanded to cover at least 75 percent of the population below the established federal poverty level.

- Government, business, industry and individuals contribute financially to the health care delivery system.

- A better balance of primary care physicians as compared to secondary and tertiary care specialists.

- A significant financial enrichment program for training, locating and retaining primary care practitioners who are willing to serve underserved populations.

- The use of physician extenders, such as nurse practitioners, especially in underserved areas.

- The use of high technology whenever it can effectively reduce health care costs.

- The use of interactive video, teleradiology and remote consultations carried over the telecommunications network when these technologies can effectively provide medical services without the expense of a full-time physician.

- Major health care issues be handled by persons with no financial interests in the medical delivery system.

- A comprehensive review of the role of regulation in the delivery of medical services.

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- A review of the concept of a single-payer system for all medical billings.
- Insurance companies operate only on the basis of community rating.
- Managed care be practiced to prevent unnecessary services.
- A complete review of mandated services.
- All health insurers be prevented from withholding, limiting or canceling coverage for individuals with serious or protracted illnesses.
- The malpractice lawsuit climate be reviewed and changed, where necessary, to lessen the need for defensive medicine.
- A comprehensive review of payment schedules of all medical care providers.

CONCLUSION

The Task Force drew conclusions and arrived at recommendations based upon the review of a significant number of documents, reports and studies, and the collective knowledge and experience of its members. This report makes no attempt to include summaries of all research, but is intended to outline the problems we face as Kansans.

The Task Force realizes that the proposals being recommended for study and change will have a fiscal impact on individuals, businesses, agencies and state government. Fiscal impact statements should be developed to study the effect of each recommendation.

It is the desire of the members of the Task Force that the recommendations become an agenda for various groups currently involved in the study of the ways and means to improve the health care delivery system.

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APPENDIX
Selected Bibliography

- News clips - USA TODAY package, Mar. 11, 1991, Section B, Pages 1, 2 and 3
  - "Why health care costs are tough to cure"
  - "Health care costs more, serves fewer"
  - "How the cost spiral started"
  - "Attitudes in conflict"
  - "Reform plans focus on access, cost of care"
  - "Technology fuels health-care inflation"

- News clips - USA TODAY package, May 6, 1991, Section B, Page 3
  - "Health spending: An economic elixir"
  - "Is health care taking too big a bite of the GNP?"
  - "How you pay your share of health care"

- Special Report - Fortune Magazine, July 1, 1991, Vol. 124, No. 1
  - "A cure for what ails medical care", Page 44
  - "Yes, companies can cut health costs", Page 52
  - "Taking on public enemy No. 1", Page 58

- Special Report - The Journal of the American Medical Association, May 15, 1991, Vol. 265, No. 19
  - "Caring for the uninsured and underinsured", Pages 2491 - 2567
  - "A framework for reform of the U.S. health care financing and provision system", Page 2529, (A proposal by the Kansas Employers Coalition on Health, Topeka, Kansas)

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- Health Care Conference - University of Kansas
  "Who pays for a healthy America?", Copyright 1990, by the University of Kansas

  - Speaker: Dr. Alan R. Nelson, past-president, The American Medical Association, Pages 6 - 18

- News clips - Associated Press

  - "Affordable care proves elusive", published in Wichita Eagle, Feb. 24, 1991, Section B, Page 8

- News clips - Wichita Eagle

  - "Medicine's middlemen target of discontent", Feb. 24, 1991, Section L, Page 1

- News column - Topeka Capital-Journal

  - "Cure for an unhealthy system" by Dr. Bill Roy, Feb. 26, 1991, Section A, Page 5

- Position paper - the Kansas Academy of Family Physicians

  - "Rural Health Policy for the 90s", Sept. 14, 1989

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Table roposals for Reform in This Issue of The Journal*

Author of Proposal	Coverage	Administration	Financing	Cost Containment/ Provider Reimbursement	Other Distinctive Features
Type I: Compulsory private insurance through employers, with government insuring nonworkers and the poor					
Kirkman-Liff	Universal	Private: insurers offer community-rated plans Government: Medicare/Medicaid enrollees get vouchers to buy private insurance	Employer/employee premium sharing; federal government pays employer share of premium for nonworkers	Copayments/cost sharing; managed care optional; reimbursement negotiated between provider and payer representatives	Copies some features of German and Dutch systems; LTC benefits unmentioned
Todd et al. (American Medical Association)	Nearly universal; excludes nonpoor nonworkers	Private: insurers offer private plans or state risk pool for uninsurable and others Government: unchanged	No change	Changes tax treatment of employee benefits; health promotion; repeals state-mandated benefits; seeks reduction in administrative costs; improves Medicaid reimbursement levels; private insurance unchanged	Adds private LTC benefits and expands Medicaid; catastrophic coverage; reforms Medicare trust fund
Rockefeller (Pepper Commission)	Universal	Private: insurers offer private plans Government: replaces Medicaid with new program for poor nonworkers and self-employed, with buy-in option for employed	Employer/employee premium sharing; existing government sources plus new taxes	Encourages use of managed care; cost sharing; improves consumers' knowledge; malpractice reform; public program pays Medicare rates; private insurance unchanged	Insurance reform, universal coverage of LTC
Bronow et al. (Physicians Who Care)	Nearly universal; excludes nonpoor nonworkers	Private: community-rated insurance plans with high deductibles Government: expanded Medicaid coverage	Employer/employee premium sharing plus individual medical savings accounts; Government: unchanged	High cost sharing; reimbursement unchanged	Adds public-private LTC coverage and catastrophic coverage
Nutter et al. (Medical Schools Section, American Medical Association)	Nearly universal; excludes nonpoor nonworkers	Private: insurance plus insurance risk pools Government: expanded Medicaid coverage	Employer/employee premium sharing; employment-based tax to cover new Medicaid costs; elderly pay for Medicare expansion	All-payer, prospective payment for hospital and professional services	Eliminates deductibility of employer contributions; adds LTC and catastrophic coverage to Medicare
Type II: Law requiring employers to provide private insurance to employees or pay equivalent tax, with government insuring nonworkers and the poor					
Davis	Universal	Private: insurers offer private plans Government: Medicare coverage for all others	Employer/employee premium sharing or employer payroll tax; income tax; general revenues	All payers adopt Medicare rates and volume performance standards for hospitals and physicians	Allows states to buy Medicaid enrollees into Medicare; LTC expansion optional for states
Schwartz (Kansas Employer Coalition on Health)	Universal	Private: insurers offer private plans Government: regional public sponsors and Medicare	Employer/employee premium sharing; tax on individuals in pool; general revenue	Malpractice reform; increased cost sharing; health promotion; insurance price increases tied to Consumer Price Index, with government adjustments; mandatory community rating of insurance	Insurers join reinsurance pools

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Table ...sals for Reform in This Issue of The Journal*

Author of Proposal	Coverage	Administration	Financing	Cost Containment/ Provider Reimbursement	Other Distinctive Features
Type II continued					
Enthoven and Kronick	Universal	Private insurance, Medicare, and public sponsors for all others	Employer/employee premium sharing; other sources unchanged	Increased cost sharing; market forces growing from competing managed care plans; changes the tax deductibility of employer health benefits	Emphasizes managed care delivery systems; no change in LTC benefits
Holahan et al.	Universal	New federal-state program for anyone not covered by an employer or Medicare	Employer/employee premium sharing or tax; existing and new state and federal tax revenue	Federal share of health expenditures tied to growth in GNP; states have strong cost-containment incentives; tax deductibility of benefits limited to standard benefit package; reimbursement unchanged	Federalizes LTC benefits; cost containment left to the states; eliminates Medicaid
Type III: Tax credit for purchase of private insurance					
Butler (Heritage Foundation)	Universal	Individuals purchase private coverage from competing insurers independent of employers; Medicare/Medicaid beneficiaries get vouchers	Individual payment for all premiums or care; government pays for poor	Changes in tax treatment of health benefits to discourage overinsuring and overuse; reimbursement unchanged	Purchase of LTC coverage at discretion of individuals
Type IV: All-government insurance system					
Roybal (US Health Act)	Universal	Single insurance system run by new agency; role for private insurers	Same sources of revenue to be paid into single account	Prospective payment, with total budget cap of 12% to 13% of GNP; all reimbursement based on Medicare rules	Adds broad range of health and LTC benefits
Grumbach et al. (Physicians for a National Health Program)	Universal	Public administrator replaces Medicare, Medicaid, and private insurance	Payroll tax; existing government revenue sources; new taxes	Annual hospital budget negotiated with state plan based on past expenditures, performance, and cost and use projections; physicians paid on negotiated fee schedule	Each state determines who runs the plan; no copayments and deductibles; LTC fully covered
Fein (Committee for National Health Insurance)	Universal	States have much flexibility with federally specified benefits and budget oversight	Federal and state taxes and premiums paid into single state agency; agency pays insurers or providers on capitated basis; federal contribution increases based on growth in GNP	State and national health care budgets; negotiated payments to institutional providers; negotiated physician fee schedule; expansion of capitated systems; consolidated administration; government review of technology and treatment effectiveness; administrative savings	Encourages state experimentation; LTC benefits unchanged

LTC indicates long-term care; GNP, gross national product

*The Journal of the American Medical Association, May 15, 1991, vol. 265, no. 19

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A PROPOSED MODEL FOR DISCUSSION

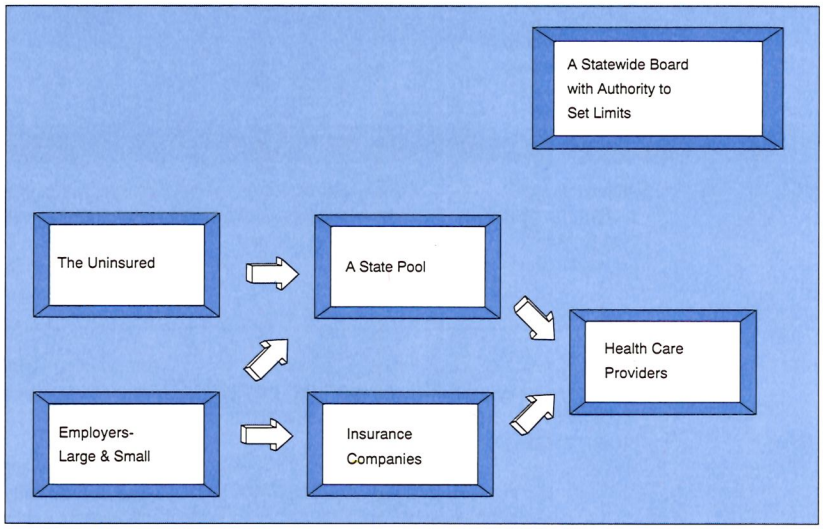
At a national forum sponsored by The Journal of the American Medical Association, held in May, 1991, in Washington, D.C., Jim Schwartz, consulting director to the Kansas Employers Coalition on Health, presented the model outlined below. This plan was subsequently published in the May 15 issue of The Journal.

Due to the attention this plan received at the national level, we think it can serve as a solid basis for discussion by a wider group of Kansans.

In pursuing this discussion, it is important to remember that small employers (hiring fewer than 50 people) will not have the same flexibility as large employers.

Consideration should be given to statewide, mandated, employer-provided health insurance, with community rating, open enrollment, and a single payer or payers system.

Such a plan would place a statewide, independent board in a position of authority to set limits on services and amounts of reimbursements. The plan is diagrammed as follows:



Under a statewide, mandated, employer-provided health insurance plan, the following would occur:

- Employers would be expected to provide health insurance coverage for their employees or pay into the state pool. Small employers would be most likely to contribute to the state pool.

- The state pool also would have money from all government programs as well as premiums paid by employers.

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- Health care for the uninsured would be paid from the state pool.

- Insurance companies would continue to provide health coverage, most likely for the large employers who have always purchased health insurance for their workers.

- The statewide, independent board would set limits on the program and negotiate services and reimbursements.

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OBJECTIVES AND GOALS OF MEMBERS OF HOUSE COMMITTEE ON:
PUBLIC HEALTH AND WELFARE
1992

Chairperson Sader stated, last year she noted at times, the goals of each of us as individuals can at times get lost in the day to day challenges that are faced, just to get the job done and get through the day. The more she has become involved in health care issues, the more convinced she is that it is vital to keep your eye on the BIG picture. Daily issues arise that must be addressed, however, the larger picture must be focused on. It is the hope then that all the small pieces that we work on daily will somehow fit into this larger scheme of things that will ultimately provide access to affordable health care for every Kansan.

Representative Ann Cozine:

Comments in 1991 were:
We will need to find ways to provide health care that meets the needs of clients better within the budget that we have.

Comments in 1992:
She still feels we need to find ways to provide health care that meets the needs of clients better within the budget that we have and we'll need to look at better ways of funding health care.

Representative Alex Scott:

Comments in 1991:
We need to predict spending so that we can get the best for the dollars we have. Need to concentrate more on prevention of problems, i.e., birth control devices and things of that kind.

Comments in 1992:
He would second his comments from 1991, and would add i.e., particularly birth control devices that also provide a chemical and physical barrier to the HIV and (AIDS) organisms.

Representative Ruth Ann Hackler:

Comments in 1991:
Her concerns were set out in paragraph 2 of minutes on January 16th, 1991. She is concerned about preventive care, what happens to children in the "system".

Comments in 1992:
She would add to her comments from last year, concerns about access to health care for all Kansans. She is particularly concerned with affordable care for the elderly, including ways to help them stay in their own homes longer, through day-care programs, in-home care, and working out some sort of formula that will enable this to be done at less cost than for care in institutions or nursing homes.

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Representative Galen Weiland:

Comments in 1991:
His concerns, i.e., medical insurance being made available to nearly everyone somehow--affordable to nearly everyone, even if it is where they buy into a plan with a physician to the ability of applicable payment for health care.

Comments for 1992: (He was unable to attend today until later on in the agenda.)

Representative Joann Flower:

She agrees with comments of others, and would like to focus on helping to keep the elderly in their own homes longer. This is getting the bang for the buck. Also is interested in prenatal care and care of children in the state.

Comments in 1992:
She would say Amen to her 1991 comments, except to correct what she said "getting bang for the buck, not bank. Her concerns remain the same.

Representative Gene Amos:

Comments in 1991:
Concerns with duplication of health services. In some cases there may be people using services that are not entitled to the Kansas dollars. He would like to find ways of correcting duplication so that we can better utilize dollars being provided. There is such a challange to meet with all the on-going programs.

Comments from 1992:
He agrees with comments made last year and would add to that, through being a member of the Joint Committee on Health Care Decisions for the 1990's he has had the opportunity to see the broadened picture of many more things being added to it. In the 5 years he has been a Legislator, he has had the opportunity to travel the State and has seen in the Western part of Kansas the problems the small rural hospitals face, just trying to stay open so they are able to provide care when it is needed. Family care is also an issue and it is important that the Universities try to attract more people to provide medical care for family primary care in these rural areas. As a business man, he knows first hand the problems and concerns with trying to provide health care the employees and their families. So, somehow, we are going to have to get a handle on health care costs. This is a field that will change considerably in the coming years.

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Representative Steve Wiard:

Comments in 1991:
He agrees with other members in their goals. He would like to see this Committee focus on being more pro-active rather than being re-active. It is appauling that 20% of Kansas children live in poverty. We have to face reality however, so perhaps we'll need to re-prioritize more than we have. We keep waiting for the Federal Government. We keep modeling Oregon, and they are on the cutting edge. Why can't Kansas be the state that is modeled? He quoted someone as saying we have a sick-care society, not a health-care society. We need to focus on preventive care.

Comments for 1992:
First, he is appreciative of the appointment as Vice-Chair of Public Health/Welfare Committee and will do the best he can on matters that come before this Committee
We need to focus on preventive care. He hopes a National debate forthcoming this Fall will speak to these problems. It is something we have not heard in 1980,'84,'88. We, in state government wait too often for the Federal government to offer programs. The Town Hall meetings on health care that are currently being held in regard to health care in Kansas are drawing very large crowds. He hopes we will continue to become more pro-active as he stated last year. He sees more legislation coming out of the Children's Initiatives Committee that met this past summer and this indicates to him we are in fact becoming more pro-active.

Representative Dorothy Flottman:
Comments in 1991:

Her concerns were about housing the mentally retarded and downsizing of housing that would affect federal funding. She feels there still should be a choice as to whether or not these people are placed in community based homes. The profoundly, mentally retarded and physically handicapped might not be properly cared for in a community based setting. She would like the Public Health/Welfare Committee and perhaps the Appropriations Committees to realize that it would not be suitable for many people in this certain population group to go into a Community setting. If the federal government funding is not available, then we may have to see about total state funding for these individuals. She noted the Winfield hospital is the only hospital that takes babies born to mothers who are on drugs.

Comments for 1992:
She would say same song, second verse. Also, many feel it is more cost effective to put the mentally retarded out into community setting, but again, those who are profoundly retarded, and or physically handicapped are not best suited for these facilities. She cited a specific individual who was sent to a dentist who was unable to treat the patient who was on a number of medications. The patient was very unruly, and caused quite a disturbance in the dentist's office. The dentist at the institutional setting was qualified to care for this patient. In these special cases, perhaps it is more cost-effective to not send this type of patient to the community based home setting.

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Representative Tom Love:

Comments in 1991:
He wanted to focus on public assistance when he asked to be assigned to this Committee. Now, he hears concerns of other members of this Committee. He had a question that has never made sense to him, i.e., people who work and do not receive a very large salary, do not have access to health care, while people who do not work, (or work very little) seem to be eligible for all types of health care services. This needs to be examined.

Comments in 1992:
To focus on getting preventive health care for the poor working class, those people who are too proud (unless they have to) to go on welfare.

Representative Sandy Praeger:

Comments in 1991:
Noted her hope there would no longer be <u>any</u> medically indigent. Affordable, quality health care is of concern to her. She is interested in the local Youth Authority and other projects being proposed and funding of those items. She noted often a teenager needs only some counseling, not being housed at $60 per day in a facility. She thinks a better job can be done and it will save money in the long run. She is also very interested in long-term care for the elderly.

Comments in 1992:
After having served on the Children's Initiatives Committee this Summer, she is very interested in assisting in implementing any of the recommendations coming out of that Committee. There is a healthy list of legislation forthcoming. She continues to be interested in the affordability and accessability of cost contained issues. She has been to a Town meeting held by Jim Slattery and the question was asked about the rationing of health care and she was surprised at the number of people in attendance that said they would agree to this type of health care. She noted it is being done in other countries, perhaps it is a coming thing here in our country. It would be a difficult program to put in place, but at some time, she thinks we will have to deal with it.

Representative Susan Wagle:

Comments from 1991:
She has been a special education teacher and worked with the underprivileged as well. She would like to see more efficient health care systems, noting complaints of some in nursing homes where many unnecessary tests have been ordered. This alone could save dollars.

Comments for 1992:
She had a little boy born in May and he is toddling around and will be here soon. She agrees with Rep. Praeger that rationing of health care may be something we'll need to think about. This year, there are exciting issues coming out of the Children's Initiatives Committee and other recommendations that are forthcoming from that Committee as well.

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Representative Neufeld:

Comments in 1991:
He has no particular personal objective, but would do all he can to help the Rural Health Care System to the best of his ability.

Comments in 1992:
He would add, the new legislation coming to Committee on EACH and PCH, will help the rural health care, and he also is concerned with the need for primary care physicians, not only in the rural areas, but also in some cities. He gave an example of the community of Hays which is now down to only 1 physician which is not enough to offer health care to the large population. He noted also, there is a need to focus on how to develop the infra-structure on care for the frail and elderly in our communities. We need to come up with less costly assisted living situations that are less costly than nursing homes that will in fact keep people out of the costly nursing home situation longer. We need to find out how to make systems like these work. We need to integrate health care systems all over the state, having the system work together rather than a separate parts working here and there. How do we figure out how EMS is an integral part of the health care system, and not just a separate part of the system, i.e., how does the nursing home situation, and the health departments, and the hospitals all fit together to provide better health care for Kansans.

Chair noted at this point, Rep. Neufeld also serves currently on the Joint Committee on Health Care Decisions for the 1990's.

Representative Eloise Lynch:

Comments in 1991:
Concerns with rural health care. She feels the importance of looking at the present statutes to see what the present situations are, what is possible for the future. Let's do look around at Oregon and see what is being done.

Comments in 1992:
She too has concerns mentioned by other members today. She agrees with Rep. Flottman about the mentally retarded and it is a problem that must be faced. The health care problem looms large and we must move ahead as rapidly as we can by looking at other states and reviewing the programs they have that are working well.

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Representative Ellen Samuelson:

Comments in 1991:
Amen, Amen, Amen.

Comments in 1992:
Her comment from last year was not meant to be a flip statement. She did agree with the concerns of others. Constituents this summer have told her of the concern and great hardship the rising cost of health care and insurance is causing. In-home help and care for the elderly is of great concern to her. She noted a situation of a town not considered medically underserved, but it has 2 doctors that both wish to retire. She is sure there are others in this same situation and it is a problem.

Representative Tom Bishop:

Comments in 1991:
Rep. Flower stole his speech. Long term Care for the elderly is vital, especially in-home services that allow the elderly to stay in their own homes, thus reducing institutional bias in our state.

Comments for 1992:
Rep. Flower "really didn't steal his speech last year". He continues to feel the long-term care for the elderly and others is still a major issue. He served on the Advisory Counsel on Aging during the Interim and was pleased that the Governor has included the expansion of the Senior Care Act in the preliminary budget. Housing model programs, from other states, that work between single family homes and institutions are in place in other states, but not in Kansas because Kansas is still in the dark ages on this issue, perhaps because of our lack of coordinated housing policy. Kansas ranks 4th in the Nation for people over 60 years of age being in Nursing Homes. This is not a figure to be proud of. It is his goal this year to reverse that trend.

Rep. Bishop was asked to repeat a joke he told last year that was not included in his comments. He did so.
The joke had to do with being a Mennonite and Mennonites are involved in service to others. This goes back to the time of Adam and Eve, and you all know that Adam was a Mennonite. He must have been, because who else but a Mennonite could be in the garden with a naked woman and be tempted by an apple.

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