Approved 2-19-92
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

10:00 a.m./p.m. on February 12, 1992 in room 313-S of the Capitol.

All members were present except:

Committee staff present:

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

Conferees appearing before the committee:

Senator Doug Walker
Korey Hartwich, K.U.
Amy Bixler, National Organization for Women
Walter Crockett, AARP
Gigi Felix, Kansas Association of Social Workers, Inc.

Chairman Ehrlich called the meeting to order at 10:00 a.m.

The Chairman called for consideration of the minutes of February 4, 5, 1992. Senator Walker made the motion to approve the minutes as presented, seconded by Senator Kanan. The motion carried.

Staff briefing and hearing on:

SB 553 - Kansas Health Care Reform Act.

Staff briefed the Committee on **SB 553**.

The Chairman called for Proponents of the bill. Senator Doug Walker, sponsor of **SB 553** submitted written testimony and stated the bill specifically defines a plan to reform the Kansas health care system. The bill would establish an 11 member Kansas Health Care Commission with an Executive Director and four separate boards which would insure access to basic health care for every Kansan, control the increasing costs of medical care and assure adequate quality of medical care. **SB 553** would control costs by placing caps on health care expenditures and by restricting physicians from owning labs and equipment, provide for a single agency to negotiate medical fees for services and to establish global budgets for hospitals. The bill contains a new certificate of need plan which establishes strict guidelines for the purchase of new expensive medical equipment and requires review and approval for facility expansion. The bill also provides for a single payer system, universal coverage for everyone meeting the 24-month residency requirement, more pay to physicians who serve in medically under served areas, collection of data to document and evaluate the number of medical services offered, the different types of services and the location of those various services. The financing package is the same as in 1991 SB 205. Senator Walker concluded his testimony by stating it is time for us to reform the health care system, to move from the current system which meets the needs of the providers to a system which meets the needs of all Kansans. (Attachment 1) Committee discussion related to the 24-month residency requirement, restricting physicians from owning labs and equipment, and taxing of interest income to help fund the program.

Korey Hartwich, University of Kansas student, read testimony from Carol Clifford, Lawrence resident, that stated her personal support of **SB 553** as being a disabled consumer of health care services, (Attachment 2) ; and Amy Bixler, National Organization for Women, read testimony from

James P. Johnston, Wichita, that stated the U. S. health care system is in crisis and enactment of **SB 553** not only will meet the cost-enhancing factors, but may well serve as an example of state action for other states to follow and possibly relieve if not eliminate the ever-increasing pressure for a federal national health insurance system, (Attachment 3).

Nancy Kindling, League of Women Voters of Kansas, submitted written testimony and appeared in support of **SB 553**. Ms. Kindling stated the League is in the middle of a national two-year study of health care to evaluate public and private mechanisms for delivery and financing of health care in the United States. The focus of the study is on access, costs, and quality of care which is, in fact, the major thrust of **SB 553.** Mrs. Kindling stated that because the bill speaks to establishing budget and policy guidelines, fee schedules, rules and regulations, monitoring, cost containment, disseminating information, and implementation of the most cost-effective methods of providing health services to all residents of the state, the League feels these are high priority components of the health care issue and should be the focus of the Committee's deliberations. (Attachment 4)

Walter H. Crockett, AARP, submitted written testimony and stated his organization voted unanimously to support **SB 553** in principle and that the AARP State Legislative Committee would be discussing the bill's specific provisions at their next meeting. Mr. Crockett stated the comments expressed today are his own and not necessarily those of his organization as a whole. He stated four factors why he supports the bill: (1) access to basic health care services, (2) single-payer system, (3) certificate-of-need, and (4) a need to see individual states establish their own health care programs. (Attachment 5)

Gigi Felix, National Association of Social Workers, Inc., submitted written testimony and stated her organization supports the concept of **SB 553**, especially the single payer option, but the following concerns were expressed: (1) 2-year residency requirement, (2) the dissolution of regulatory bodies within the state, (3) the co-payment schedule, and (4) minimum coverages. Other aspects of the bill were also presented. (Attachment 6)

The Chairman announced that members of the Kansas State Nursing Association will be addressing the Committee the following day, and that the hearing on **SB 553** will continue after their presentation.

The meeting was adjourned at 11:00 a.m. The next meeting is scheduled for February 13, 1992, 10:00 a.m., Room 313-S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-12-92

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Hilda Enoch, 1500 El Dorado Dr. Lawrence, KS 66047	Kaw Valley Chap. Older Women's League O.W.L.
Rev. Don L Walker West Kansas	RETIRED
V. Faye Yeager Leon Kans. 67074	Leon Seniors Citizens
Nydine Dilts, Leon, Kansas 67074	Leon Senior Citizens
Powell Heide Rt 2 Augusta, Ks	" "
Mary Heide Rt 2, Augusta, Ks	CPAAA, Butler, CA Council
Carol Macdonald 4301 Huntoon	Kansas Dental Board
Franklin Sandridge RR#1	Paola Kansas
June F. Sandridge R#1, Paola, Ks.	Council For Aging Bd.
Katherine Brandt Route 2 Paola, Ks	
Aletha Andrews RR. 2 Box 54	Osawatomie, Ks. 66064
Carl Smithhisler	Kansas Dental Assn.
Paul Johnson	PACK
Jerry Peterson	Ks Found. For Medical Care
Terri Roberts	KSNA
Nancy Kundinger	League of Women Voters
Amy C Ryder	N.O.W.
Clayton W Whitstone	S.C.
Bea Whitstone	Lone Senior Citizen

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-12-92

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Bill Thompson, Topeka	KS Dept. of Commerce
Roger Fraundorf, Topeka	Ks. Govt Council
Tom Hitchcock	Bd. of Pharmacy
David Hanzlick	KS Dental Assn
Sandie Hampton	MPA
S. Graham Bailey	BCBSK
Fred Palenske	"
SHELBY SMITH	WESLEY FOUNDATION
Laura McClure	Self
Leland Smoot	WIBA
SUZANNE KLINKER	CONG JIM SLATTERY OFFICE
Pat Watson	Mid America Nutr Prog.
Vickie Chadwell	Mid-America Nutrition Prog
Elizabeth Maxwell	Mid-America Dietetic Assn
Marilyn Bradt	KINH
Pat Johnson	KSBN
Jane Klynn	KSBN
Brad Smoot	BCBS
Margaret M. Higgs	Self County Advers Council on Aging

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE Feb 12, 1992

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Alberine Larson	Self
Larry Buening	Board of Healing Arts
Wendell Strom	AARP - CCTF
Roger Kirkwood Topeka	AARP-CCTF-Kansas
Marquita Brant - Ottawa	Mid America Nutrition Program
Marilyn Wagner - Mound City	Linn Co Nutrition Program
Linda Lubensky, Lawrence	KS Home Care Assoc.
Ed Lewis Louisburg Kansas	South View Homecare
Shawn Jaramillo Ottawa	South View Homecare
Jack Ingram Topeka	KCA
ROGER R. TOBIAS, MD Lyons	Family Physician Kansas Academy, F.P.
Sharon Huffman - Topeka	KCDC
Mark Tey Osawatomie	SRS
Norma Stephens "	"
Don Allen	Anderson County Council on Aged
Sheri Bettis, Ottawa	ECKAAA
Donna K Martin, Ottawa	ECKAAA
Karen Adams Ottawa	ECKAAA

STATE OF KANSAS

DOUG WALKER
SENATOR, 12TH DISTRICT
MIAMI, BOURBON, LINN,
ANDERSON, ALLEN AND
NEOSHO COUNTIES

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

TESTIMONY SUPPORTING PASSAGE OF

SENATE BILL 553

February 12, 1992

Last year I introduced legislation that provided for access to basic medical services to every Kansan and established a single agency to pay all covered medical expenses.

That bill moved the discussion from "should we reform the system?" to "how" to reform the system. S.B. 553 moves the discussion a step further by specifically defining a plan to reform the Kansas health care system.

Senate Bill 553 establishes an 11-member Kansas Health Care Commission with an Executive Director and four separate boards which will insure access to basic health care for every Kansan, control the increasing costs of medical care and assure adequate quality of medical care.

COST CONTROL

This bill controls costs by placing caps on health care expenditures and by restricting physicians from owning labs and equipment by which they profit from patient referrals. Further, it provides for a single agency to negotiate medical fees for services and to establish global budgets for hospitals. The bill contains a new certificate of need plan which establishes strict guidelines for the purchase of new expensive medical equipment and requires review and approval for facility expansion.

By going to a single payor system we should realize a 13% savings in all health care expenditures by the reduction in paperwork and administrative costs.

ACCESS

The bill provides universal coverage to every person who meets the 24-month residency requirements. There are no exceptions for preexisting conditions or the level of income. It also specifically lists the explicit services covered in the minimum benefits package. The bill also recognizes that, even though everyone is covered by insurance, the services needed may not exist in certain parts of the state thereby effectively denying access.

There are provisions which allow for physicians who serve in medically underserved areas to be paid more than their counterparts in the more lucrative areas of the state.

QUALITY OF CARE

This legislation will, for the first time, provide for the collection of data to document and evaluate the number of medical services offered, the different types of services and the location of those various services. We will be able to document areas of the state which have an excess of equipment or services, and identify specific services in specific areas which are in need of services. We will be able to evaluate the entire realm of health services offered in the state and the actual costs associated with providing those services. It will give us the

ability to do comprehensive statewide health planning.

I want to emphasize that this is a plan that can be successfully implemented on the state level. The state is currently the vehicle which the federal government uses to implement all of its health programs. If we wait for the federal government to implement some form of national health plan, we will be charged with implementing their plan. We will be forced to comply with their mandates and to follow their guidelines and timeframes, whether they meet our needs or not and whether they are cost-effective for us or not. With Senate Bill 553, we will develop and implement a health care system which meets OUR needs, not just some federal guidelines. This is a unique opportunity for Kansas to take a leadership role in reforming health care in the United States. The federal government will participate in the health care process by having input and making sure the plan will do all that it is intended to do. I can assure you that the federal government will make sure that this plan will work and meets the needs of all Kansans before they grant any federal Medicaid/Medicare waivers.

The financing package is the same as in last year's SB 205: an 8% employer payroll tax, with a four-year phase in for small employers; a health premium surcharge on individual income taxes from 0% to 7% based on income; a 10% tax on alcohol and tobacco products; and a 2% tax on interest and stock dividends in excess of $1,000. State appropriated monies provided by legislation for health care, copayments for certain services, and federal Medicaid and Medicare dollars (with the exception of basic long-term care dollars) will also help fund the plan.

I will say right now that any alternative funding schemes can, and should, be considered. I am not irrevocably tied to these funding mechanisms but I felt that it would be irresponsible to present a health care plan without a funding design.

What you need to keep in mind with this plan is that we will not spend more money on health care in Kansas than we are currently spending. The taxes in this bill should not be considered an additional tax burden. We are simply collecting the dollars we spend on health care now in a different way. There will be no more health insurance premiums, or deductibles for either employee or employer.

The plan will be phased in over a period of time, with the entire plan lapsing should federal waivers not be received within two years.

The most significant thing to keep in mind about this plan is that it is a complete plan. It addresses the problems of access, cost control, and quality of care and financing. Any plan which does not address all of these areas simultaneously is inadequate and will never solve the problems in health care and should not be considered long term solutions to the problem.

I would also like to address the lists of proponents and opponents who are lined up to testify on this bill. I think that

list, in and of itself, emphasizes the importance of this bill and, indeed, the entire issue.

Last year when we had hearings on SB 205, there were 13 proponents and 7 opponents. What concerned me then was that certain proponents should have been opponents. Last year it was still safe to favor the "concept" of health care reform without having to identify the specifics. That's why the Kansas Medical Society and the Kansas Hospital Association spoke as proponents. S.B. 205 was in reality a "concept" bill. It spoke only in generalities and did not have a chance of passing. It was safe to be a proponent, one who went on record as favoring reform in health care.

After looking at this year's list of proponents and opponents, I feel confident that SB 553 is much more on target. You cannot support only the "concept' of reform and support SB 553. Senate Bill 553 is specific. It is clearly defined. To support SB 553 you have to truly support health care reform and not just the "concept". SENATE BILL 553 SEPARATES THE TRUE REFORMERS FROM THE REFORM DEMAGOGUES.

Listen very carefully to the opponents. Keep in mind who they represent Keep in mind how this bill will affect them. We will hear much rhetorical concern about quality of care and availability of care and other noble sounding concerns. But remember the bottom line: Opposition to this bill is not that it will fail to meet the health needs of all Kansans more efficiently or more cost-effectively than the current system. The real objection to this legislation by the opponents is that it is going to affect their ability to make millions of dollars from the sick in this state. You will hear them express fear that this bill will lead to rationing of health care. And I hope this bill will cause us to reexamine how we spend our health care dollars and cause us to prioritize our spending. We need to do that. Opponents of this legislation do not really fear rationing of health care -- they fear the rationing of the health care dollar. Regardless of the eloquent and principled rhetoric about their concern for the poor and the quality of care, their primary objection to this bill is economics and the loss of control.

I believe that SB 553 is on target. The proponents are those one would expect -- the recipients of health care. The list of opponents -- the providers of health care. Members of this committee, I submit to you that it is time for us to reform the health care system, to move from the current system which meets the needs of the providers to a system which meets the needs of all Kansans.

STATE OF KANSAS

DOUG WALKER
SENATOR, 12TH DISTRICT
MIAMI, BOURBON, LINN,
ANDERSON, ALLEN AND
NEOSHO COUNTIES

TOPEKA

SENATE CHAMBER

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

QUESTIONS:

1. How can we implement this system without knowing exactly how much it will cost and whether the revenues are sufficient to meet those costs?

Currently the data does not exist to allow us to determine the costs of any comprehensive plan. It will take several years to implement this plan. During that time we can more accurately pinpoint costs and revenue projections. The federal government will not allow us to implement this plan if they feel our revenues are inadequate.

2. Government can't do anything efficiently. Why should we turn health care over to the government?

No one likes to let government become involved. The whole concept of more government intervention in anything runs counter to the American tradition of independence. Government is, however, forced to intervene when the private sector fails to meet a need or operates in a manner that is contrary to the public interest. Government builds roads and bridges. Governments protects us from foreign aggressors. Government rules protect us from the abuses of other individuals. No one is suggesting that government get out of these areas. Government is also responsible for protecting individual rights and insuring the public welfare. Nobody is suggesting that we eliminate social security. Nobody is suggesting that we eliminate workers compensation. No one is suggesting that we eliminate public education. No one is suggesting that we eliminate Medicaid or Medicare. Government has a role to play in protecting its citizens.

The private health care industry has not developed in a manner in which the public interest is best served. The problems associated with health care have not developed overnight and there is absolutely no indication that the industry is capable of reforming itself.

Despite our reluctance to move toward government intervention, the current health care system has done such a poor job of meeting the needs of the nation that the public is demanding that government fix the problem.

1-4

If the current system were working, I would not be advocating these changes.

3. Canada has problems with their system and there are reports of Canadians coming to the United States for treatment because they cannot get it in their country. Why should we go to that type of system?

Canada spends far less on health care than the United States. Canada covers all of its citizens while the U.S. has 37 million uninsured. Statistical outcomes for heart disease are identical in both the U.S. and Canada. It is estimated that 40% of the heart operations in the U.S. are unnecessary while Canada utilizes other recognized treatments. Surveys indicate that only 3% of Canadians would prefer the U.S. system over theirs (Jan./Feb. 1991 issue, IN HEALTH magazine, article by Anthony Schmitz). Surveys indicate that 72% of Americans would prefer the Canadian system to the present one.

4. How does this plan compare to the President's Plan?

President Bush's plan is <u>not reform</u>. His proposal, costing $100 billion over 5 years, calling for tax credits, vouchers, and tax deductions, is totally isolated from the realities of the insurance market. His plan would allow over 5 million people to remain uninsured and it does nothing to control costs. His plan is welfare for physicians. It helps to guarantee their incomes by making insurance available to more individuals, ergo, enabling more individuals to pay their bills. At the same time, it reduces Medicaid and Medicare payments paid to providers, many of whom already are refusing to see Medicaid and Medicare patients because of excessively low reimbursement. By further reducing their reimbursement, many more providers will refuse to see Medicaid patients, further reducing access.

To the Public Health and Welfare Committee
of the Kansas State Senate

Mr. Chairman and Members of the Committee:

I am writing to support Senate Bill No. 553, the Kansas health care reform act, based on my personal experience as a disabled consumer of health care services, my five years of research on health care reform, and my work with the League of Women Voters, the Older Women's League, Kansans for Improvement of Nursing Homes, and Physicians for a National Health Program.

I believe it is unlikely that the severe problems of cost and access in in our Kansas health care system will be solved on a national level within the next five years, and I don't think we can tolerate the economic and human costs of waiting for national action.

I believe that state demonstration programs are a sound way to begin national health care reform, because strengths and weaknesses of these programs can be evaluated, and necessary improvements can be made before broad changes are begun nationwide.

S.B. 553 establishes a streamlined and integrated framework for the funding and administration of health care in Kansas, while providing freedom of choice for the consumer in selecting health care providers, and freedom for providers to choose their own modes of practice.

S.B. 553 establishes a single-payer system which, alone among all the "play or pay" plans and proposals for incremental changes, will provide real cost containment by

1 - eliminating unnecessary and unproductive administrative tasks and their tremendous cost,

2 - giving the state system single-payer bargaining power with physicians, hospitals, and the pharmaceutical industry, plus savings due to economy of scale, and

3 - beginning the rational coordination of research and development, professional education, and distribution of resources, eliminating wasteful duplication, and ensuring that services, facilities, and technology will be available when and where they are needed.

I believe this system would be more efficient and cost-effective if it were financed solely by taxes without copayments, but at least the negative impact of copayments on prevention and early intervention has been minimized by exempting lower income families from paying them. I support the kinds of taxes proposed in this bill and would be willing to pay them at a far higher rate, which I think will be necessary to finance the plan fully.

I feel strongly that long-term care and more extensive mental health coverage should be included in S.B. 553, but I respectfully urge the committee to approve this bill as it stands, and give all Kansans the opportunity to participate, through their representatives, in a fair and open debate on its merits in the Kansas Senate this year. Thank you.

Senate P H&W
Attachment #2
2-12-92

February 8, 1992

Carol Clifford
801 Mississippi St.
Lawrence, KS 66044

SUMMARY OF TESTIMONY GIVEN BEFORE THE COMMITTEE OF PUBLIC HEALTH & WELFARE
February 12, 1992
RELATING TO SB 553

I wish to thank the committee for being given the opportunity to appear and speak in favor of S.B. 553.

The U.S. health care system is in crisis. Approximately 34 to 37 million people are uninsured and an equal number under-insured. There is also a grossly unequal distribution of medical personnel and equipment in addition to the highest medical costs in the world and which costs continue to rise rapidly. Increasing medical costs retard the growth of money wages, as an increasing amount of the total pay or salary package goes for health insurance expenses and places our business firms at a competitive disadvantage in international markets. Recent data confirm that American automobile manufacturers must factor into the price of each automobile manufactured in the United States approximately $700.00 to cover employee health costs. Similar data for foreign automobile manufacturers either have virtually no health costs in their product or those that do only average from $200 to $250 per product. Medical costs are driven up by several factors including (1) excessive utilization of expensive and high technology equipment (2) unnecessary medical and particularly surgical procedures (3) excess capacity for hospital and rehabilitation services (4) grossly high administrative expenses (5) transfer billing practices and (6) exorbitant pharmaceutical costs.

While each of the above-enumerated factors cannot be explored in exhaustive detail, certain conclusions are evident.

Senate P H&W
Attachment #3
2-12-92

Concerning (1) studies have shown that medical care providers order expensive tests using highly sophisticated technologies where sufficent clinical evidence to justify such procedures is inadequate or non-existent. Further studies show that providers not infrequently refer patients to laboratories or other specialized clinics for high cost testing and in which the medical care provider has a financial interest.

(2) A Rand Corporation study has indicated that at least 40% of open-heart surgies are unnecessary. Other studies have shown that 20% or more of tonsillectomies and hysterectomies are unnecessary.

(3) Studies have shown that in some areas of the country there is vast underutilization of hospital beds, along with excessive facilities for occupational and rehabilitative therapies.

(4) Administrative expenses (primarily the costs imposed by over 1,500 private health insurance carriers) absorb up to 24% of the total health care dollar. For each patient who comes in contact with the system, detailed bills must be submitted; claims must be checked and approved; someone must verify that deductibles have been met, co-payments made, prior authorizations obtained, etc. It is fair to say that the American health care system is buried in paper work. This paper shuffling does not save money or treat patients, but simply determines who is going to pay the bill. Overhead costs in U.S. private insurance firms average 11.9% of premiums, compared with 3.2% in the American Medicare program.

It is established that other countries run their entire health care systems on 8 to 11% of total health care revenues. The General Accounting Office estimates that wasteful administrative costs in the U.S. in 1991 totaled $67 billion.

In addition to our health costs being excessively high, the distribution of those costs among the people in different income classes is grossly disproportionate. Heavy financial burdens are imposed on those least able to afford them.

(5) Transfer billing practices are used throughout the United States, but studies and data are rare due to the difficulty of locating and verifying medical care providers who engage in such practices. Obviously, the duty to render hospital or medical care to an uninsured person increases the pressure on the medical care provider to engage in the practice. This means that many of our hospital bills have inputs that should not be there, as well as exorbitant expenses for relatively inexpensive procedures. Obviously this means that those of us who are insured and are required to pay higher deductibles or co-payments or higher premiums end up paying for those who are uninsured or underinsured.

(6) The cost of prescription drugs in the United States where most of the drugs are produced are significantly higher to consumers in the United States than they are in our adjoining country of Canada. From a selected list of the 36 of the top 100 name-brand prescription medications, the differential in higher costs ranges from 26.6% to 81.2%. (See attached Exhibit 1.)

The argument has been made that we should simply let the "free market" allocate our medical resources. However, we have not had a free market in medicine for decades, as we all know, (Medicare and Medicaid, for example) and the free market that remains in medicine has resulted in the present crisis which faces our country in this field.

CONCLUSION

In our federal-state scheme of government, states have often taken the lead in implementing governmental programs because of failures of policy at the federal level. Indeed, effective state action has served to prevent partial or total preemption of the field by the federal government. Enactment of S.B. 553 not only meets the cost-enhancing factors itemizied above, but may well serve as an example of state action for other states to follow and possibly relieve, if not eliminate, the ever-increasing pressure for a federal national health insurance system.

JAMES P. JOHNSTON
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CANADIAN vs. U.S. DRUG PRICES

Exhibit

PRICES SHOWN WERE IN EFFECT IN BOTH COUNTRIES ON MAY 15, 1990

Column "CANADA" shows the net wholesale cost (in U.S. Dollars) to Canadian Pharmacists.
Column "U.S." shows the net wholesale cost to pharmacists in the U.S.
Column "DIFF" shows the difference between the two costs.

PRODUCT	CANADA	U.S.	DIFF
Ativan 1 mg tabs	$ 7.81	$ 41.61	81.2%
Ceclor 250 mg caps.	$ 78.43	$134.17	41.5%
Clinoril 200 mg tabs	$ 54.67	$ 84.66	35.4%
Corgard 40 mg tabs.	$ 34.27	$ 59.09	42.0%
Coumadin 5 mg tabs.	$ 17.90	$ 34.45	48.0%
Demulen tabs.	$ 10.39	$ 17.45	40.4%
Dilantin 100 mg caps.	$ 5.02	$ 11.29	55.5%
Duricef 500 mg caps.	$ 92.52	$189.39	51.1%
Dyazide caps.	$ 13.28	$ 28.40	53.2%
E-Mycin 250 mg tabs	$ 11.63	$ 21.64	46.2%
Entex LA tabs.	$ 22.93	$ 38.26	40.0%
Feldene 20 mg caps.	$104.80	$156.96	33.2%
Flexeril 10 mg tabs	$ 43.07	$ 69.68	38.1%
Halcion 0.25 mg tabs	$ 15.63	$ 43.39	63.9%
Inderal 20 mg tabs.	$ 13.63	$ 22.51	39.4%
Keflex 250 mg	$ 26.84	$ 85.87	68.7%
Lasix 40 mg tabs.	$ 8.32	$ 13.48	38.2%
Lopressor 50 mg tabs.	$ 18.23	$ 35.38	48.4%
Minipress 2 mg caps	$ 26.31	$ 35.85	26.6%
Naprosyn 375 mg tabs.	$ 41.00	$ 70.91	42.1%
Ortho-Novum 777 tabs.	$ 7.88	$ 16.24	51.4%
Pepcid 20 mg tabs.	$ 21.30	$ 29.22	27.1%
Percocet 5 tabs.	$ 30.47	$ 47.50	35.8%
Premarin 1.25 mg tabs.	$ 18.95	$ 30.82	38.5%
Retin A Cream 0.025%	$ 9.44	$ 20.59	54.7%
Seldane 60 mg tabs.	$ 36.54	$ 61.02	40.1%
Slow-K tabs	$ 7.44	$ 11.57	35.6%
Synthroid 0.1 mg tabs.	$ 4.20	$ 13.50	68.8%
Tagamet 300 mg tabs.	$ 28.71	$ 51.88	44.6%
Tavist 1 tabs.	$ 22.84	$ 48.76	53.1%
Tenormin 50 mg tabs.	$ 43.63	$ 61.12	28.6%
Triphasil	$ 8.82	$ 14.52	39.2%
Valium 5 mg tabs.	$ 10.75	$ 39.85	73.0%
Ventolin Inhaler	$ 9.43	$ 14.78	36.1%
Xanax 0.25 mg tabs.	$ 13.82	$ 34.92	60.0%
Zantac 150 mg tabs.	$ 49.59	$ 70.91	30.0%

This list shows the price disparity of 36 of the top 100 name-brand prescription medications which were dispensed to patients in the United States in 1989; we have listed only those of the top 100 of which the price disparity is greater than 25%.

Published by: Pharmacy Freedom Fund, 1500 Clenegas, Fort Worth, TX 76112

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

Senator Roy Ehrlich , Chairman

February 12, I992

Senator Ehrlich and members of the committee, I'm Nancy Kindling, Legislative Chairman for the League of Women Voters of Kansas which is a nonpartisan political organization. The League, while not supporting or opposing any political candidate or party does promote political responsibility through informed and active participation of citizens in government.

I am here today in support of SB 553; the Kansas Health Care Reform Act.

The League of Women Voters is in the middle of a national two-year study of health care to evaluate public and private mechanisms for delivery and financing of health care in the United States. The focus of the study is on access, cost, and quality of care which is, in fact, the major thrust of SB 553. Attached to this testimony is an outline of our national study and the areas to be addressed leading to a consensus from all our Leagues around the country by the end of next year.

However, the League of Women Voters of Kansas adopted, in 1989 by consensus, a Medical Indigence position which state that:

1. "basic health care should be available to all citizens of Kansas" and
2 "in the absence of federal action, the state should take the responsibility for devising a plan to care for the medically indigent (those who are uninsured and underinsured) and to provide funding and program guidelines for health and health education."

SB 553 speaks to establishing budget and policy guidelines, fee schedules, rules and regulations, monitoring, cost containment, disseminating information, and implementation of the most cost-effective methods of providing health services to all residents of the state, with priority given to:

1. Increased reliance on primary and preventive care,
2. Community based alternatives to institutional long term care, and
3. Increased emphasis on alternative providers and modes of care.

These are all high priority components of the health care issue and we believe the focus of your deliberations.

Funding is always a major part of any proposal and the League supports a reasonably balanced tax mix to support services.

Many sub-systems are a part of the health care delivery system. All are involved in what we have come to term a "Health Care Crisis". All should be incorporated on the Board of Directors to assure that any health care plan in Kansas will be successful. We, in League, commend you for including, on the Board of Directors, two members from the general public who have no direct contact with the delivery of health care services.

Thank you for allowing me to appear before you today.

Nancy Kindling

Senate P H&W
Attachment #4
2-12-92

SUMMARY OF NATIONAL HEALTH CARE STUDY
LEAGUE OF WOMEN VOTERS

FIRST YEAR OF STUDY

The following lists are topics which must be discussed before arriving at a consensus for developing a health care policy for the League of Women Voters U.S.A.)

Goals of U.S. Health Care Policy? *(This is a broad philosophical question. The following areas are some which need to be addressed when arriving at goals)*

Establishing a minimum basic level of care for all U.S. residents.
Health care at an affordable cost to the individual patient.
Quality standards of care.
Consumer choice in the selection of health care providers.
Provider choice in the selection of practice.
Efficient and economical delivery of care.
A reasonable total national expenditure level for health care.
Equitable distribution of health care services.
Advancement of medical research and technology.
Other.

Minimum Basic Level of Care? *(Allows for the definition of minimum basic care. Recognize that each criteria accepted will increase cost of basic minimum care.)*

Disease prevention.
Health promotion and education.
Primary care.
Acute medical care.
Long-term care.
Mental health care.
Dental care.
Vision care.
Hearing problems.
Other.

Equitable Distribution of Health Care Services? *(Focuses on standards for ensuring a just distribution of health care services.)*

Community and experience rating. *(method of insurers to establish premium levels.)*
Medically undeserved areas.
Professional training in needed areas of care.
A mandated uniform service level for all publicly funded programs.
Insurance pools.
Other.

Co: ıtrol Methods? *(Addresses efficiency and economy on the delivery of health care services.)*

Provide consumer accountability, deductibles and copayments.

A mandatory second opinion before serious surgery or extensive treatment.

Regional planning.

Utilization reviews of providers' health care services.

Maximum level of public reimbursement to providers.

"Capitation" or fixed, per capita payments to providers.

Managed care.

Simplified administration.

Malpractice reform.

Other.

Allocation of Health Care Resources? *What criteria should be used to "ration" limited health care resources to individuals in need of care?)*

Ability of patient to pay.

Age.

An urgent medical condition.

Life expectancy of patient.

Expected outcome of the treatment.

Cost of procedure.

Duration of care.

Patient and family wishes.

Quality of life after treatment.

The analysis of these ethical issues is not an easy process. There are no right or wrong answers, and each person's choices reflect a sincere effort to address the most difficult areas in health care today.

SECOND YEAR OF STUDY

Financing Health Care

Looks at the equitable options for financing any health care plan.

TESTIMONY FOR THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
CONCERNING SENATE BILL 553

Topeka, Kansas, February 12, 1992

Mr. Chairman and Members of the Committee:

I am Walter H. Crockett, Chair of the State Legislative Committee of Kansas AARP.

In the view of Kansas AARP, providing access to health care and dealing with the high cost of health care constitute two of the most important problems that face our state and the nation. They are problems we must address and resolve within the next few years. Last year, we testified before this committee in support of Senator Walker's earlier bill, SB-209. In January, the AARP State Legislative Committee and Capital City Task Force met with Senator Walker to discuss his revised bill, SB-553. Afterward, we voted unanimously to support this bill in principal. We commend Senator Walker for advocating a sensible reorganization of our failing health care system.

Because SB-553 was not in final form when we talked with Senator Walker, the AARP State Legislative Committee was not able in January to endorse it in detail. We will discuss its specific provisions at our February meeting, which will be held next week. Therefore, I must stipulate that the glowing comments I make today about the bill are my own opinions, not necessarily those of the committee as a whole.

After studying SB-553 , I believe that Senator Walker has made important improvements on his earlier bill. In particular, the removal of copayment requirements for prenatal care and other procedures increases the likelihood that low-income Kansans will receive preventive care, something that is critical to the improvement of our health care system. Other changes are equally meritorious; however, instead of commenting on all of the laudable provisions of this bill, let me make four relatively general comments about it.

At the top of the list of advantages of this bill is the fact that it ensures that everyone in the state will have access to basic health care services. As we all know for many of our citizens, the high price of health care; the escalating cost of health insurance; even, for people with severe conditions, the inability to find a company that will sell them health insurance, has meant that they seek out medical care only as a last resort, when their condition has become critical. In particular, preventive care such as prenatal care, vaccinations, or regular physical examinations, is sacrificed; this often results in costly treatments for conditions that could have been averted by early intervention. A program such as the one envisioned by SB-553 will guarantee that all Kansans, regardless of the state of their health or their finances, will have access to basic health care.

A second major advantage is that a single-payer system, as proposed in this bill, eliminates the sizable, largely unnecessary body of paper work that plagues our present system. Our hospitals, doctors' offices, and other health care facilities must hire teams of persons to deal with

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a complex, sometimes bewildering system of forms and billing procedures. Just simplifying those procedures will permit us to re-direct millions of dollars from clerical services to medical services.

A third major advantage of this bill is that it promises to release us from the costly and unnecessary proliferation of expensive medical technology and facilities that now bedevils us. I have been told by people who should know that the "certificate of need" program which Kansas abandoned some years ago never worked as it was intended to. I am not prepared to quarrel with that assertion. But I have talked with AARP colleagues from other states who report that their certificate-of-need programs do work. Clearly, we need to bring to a halt this unnecessary burgeoning of expensive medical technologies and facilities that is taking place in our state. There are presently more MRI units in Wichita than in all of Canada. Last summer, the Joint Committee on Health Care Decisions for the 1990's was told that two rehabilitation hospitals were under construction in Wichita even though the consensus of medical opinion held that neither of them was needed. Attempts were made to persuade the builders of those facilities--one of them a non-profit hospital, the other a health care corporation--not to proceed. But persuasion was not enough; both facilities will be completed in the near future. And a member of our AARP State Legislative Committee, a retired nurse, reports that at least one of the new rehabilitation hospitals is beginning an aggressive marketing program to ensure that its beds will be filled. If we are to control the soaring costs of health care, some way must be found to halt this unnecessary but pervasive duplication of technology and facilities. In my view, the most reasonable means to this end is to build on our own past experience and that of other states and to devise a rational, effective certificate-of-need program.

Finally, I want to explain why I think the state of Kansas ought to take the lead in passing this legislation. I have heard it argued that such legislation should be a federal responsibility, not a state one. But, like many other citizens, I have little faith in the capacity of the federal government to formulate a single, detailed program of access to health care that will be applicable to such a diverse body of states. I would like to see individual states develop their own plans according to their own needs, drawing on the ideas and programs of their sister states where possible, but without the burden of federal mandates and oversight. At some later time, perhaps, there may be a federal role in coordinating and helping to finance state programs, but let the separate states establish their own programs from the beginning.

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Gigi Felix, LMSW
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Testimony on SB553

Good Morning Sen. Ehrlich and members of the Senate Public Health and Welfare Committee. I am appearing before you in support of SB553, and to express a few concerns my association has with its present form. Overall, we believe that the "single payer" option for heath care is the best, and fairest way to approach the health care crisis in the nation, and specifically in Kansas. We applaud the sponsors of this legislation their choice in format to address the crisis of the uninsured and the under insured of our state.

I will briefly address the concerns we have, then the items of support:

CONCERNS:

(2,1-4) <u>The definition of "Resident"</u> mandates a 2 year residency in Kansas. Our concerns are those who move into Kansas by choice, or because of an employer's move (i.e. Santa Fe workers coming to Topeka), and the homeless of our state. These persons will be caught outside the residency requirements. In addition, there is no indication of what health care services would be available to these people. It is my guess that private insurers will increase rates for policy holders caused by the reduced pools of insureds. This will increases the problem of affordable health care for these people, and they are among the most vulnerable. (See also [3,4-5] where eligibility is discussed)

(7,10-31) <u>The dissolution of regulatory bodies within the state</u> is of concern for several reasons:

1) Who will make up the regulatory bodies for the professions? What will their backgrounds in education, profession, and experience be? What will be the appointment criteria?

2) Who is this board accountable to? It is of great concern that ALL regulatory bodies remain independent of influence, and control of the state agencies, and professions.

3) How will this be financed? Is this board appointed or staff? How many will sit on it? etc.

4) What is the check and balance on this board?

(18,15...) <u>The co-payment schedule</u> is much improved over last year's version of the single payer option for Kansas in that it eliminates co-pay for persons under the 25K income bracket.

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There is no delineation for households with more than one wage earner. This will cause a hardship if two people are each making 25K or more.

Furthermore, the burden of financing this plan seems to be on the middle class Kansan. According tot he Kansas Dept. of Revenue, in 1989 more than 1/4 of the state's taxpayers fell into the income bracket of 25K - 50K (27%), and only 13% had incomes over 50K. This means the people in the middle will bear the highest burden of revenue for the program. Sixty percent (60%) will have no co-pay obligation, but will be paying the income tax surcharge.

My association's position, as last year is that the co-pay option for funding should be removed entirely.

The attached breakdown shows the regressive nature of the proposed co-pay schedule in that persons making both 25K and 83K pay the same exact percentage of their income to the co-pay + income tax surcharge (12%). I am sure you will agree that the same 12% has a far greater impact on someone making $25,000 ($3,000) then on someone making $83,000 ($9,980).

The difference between someone at $24,999, and someone at $25,000 is also considerable ($1,000).

(16,36 - 18,11) Minimum coverages shows a great deal of thought and it approaches comprehensive. Some coverages we would suggest be included are:

- sick babies
- inpatient psychiatric care
- out patient, ambulatory substance abuse care (a far more efficient use of funds)
- routine dental care (or at least the care to eliminate pain and suffering)

(18,42...) In the exclusion list is the phrase "basic nursing home care" I don't understand what that means. Is it the basic human needs care such as bathing, medication delivery, food, shelter, etc? This phrase should either be clarified or eliminated.

(1,22 & 18, 43 - 19, 1-2) Health care providers in this plan are not allowed to refuse folks for preexisting conditions (good!), or on the basis or "race, color, ... or other non medical criteria." My concern is that providers will be able to refuse for "medical conditions", not necessarily pre existing, such as HIV+, AIDS, ARC, or other serious illnesses such as cancer, etc. I believe this phrase to be confusing.

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SUPPORT ISSUES

Considering the depth of this legislation, we actually have fairly few concerns. We support the other aspects of the bill including:

(1,22-23) the definition of "eligible person" covering every resident of Kansas;

(3,11 - 5,20) the composition of the Commission, and its duties;

(8,19 - 31) the duties of the health planning board, especially the development of regional service areas, and the shift to preventative health strategies;

(9,22 - 24) the consideration of payment for individual care providers;

(10,39 - 42) that cost containment is to be considered equally with other factors of need in granting facility permits; and

(16,36 - 18,11) the comprehensiveness of the minimum care standards (although not complete enough as discussed previously).

(18,26 - 28) that there can not be co-pay for the care of a child, or prenatal care for pregnant women.

In summary, K-NASW supports the effort, and intent of SB553, and strongly urge you to consider our amendments for more equitable health care coverage for ALL Kansans.

Thank you for your time and the opportunity to address you this morning.

% Population of Kansas (Dept. of Revenue Tax '89)

INCOME		CO-PAY	SURCHARGE	TOTAL	%
-0-					
$5,100	60%	-0-	$51 (1%)	$51	1%
9,800		-0-	98 (")	98	"
11,000		-0-	330 (3%)	330	3%
24,000		-0-	720 (")	720	"
25,000	27%	2,000 (MAX)	1,000 (4%)	3,000	12%
38,000		2,000 (")	1,520 (")	3,520	9%
42,000		4,000 (MAX)	2,100 (5%)	6,100	15%
50,000		4,000 (")	2,500 (")	6,500	13%
73,000	11%	4,000 (")	3,650 (")	7,650	10%
75,000		5,000 (MAX)	4,500 (6%)	9,500	13%
83,000		5,000 (")	4,980 "	9,980	12%
100,000	2%	10,000 (MAX)	7,000 (7%)	17,000	17%
250,000		10,000 (")	17,000 "	27,000	11%

75K, 250K + 25K almost same % of income

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Kansas Individual Income Tax by Adjusted Gross Income Bracket

Resident Taxpayers, Tax Year 1989

Effective Tax Rate on Adjusted Gross Income	Adjusted Gross Income Brackets	Number of Returns	Adjusted Gross Income	Tax Liability After All Credits
	No AGI -	23,292		
0.37%	$0 - $5,000	117,304	$359,884,572	$1,313,921
0.86%	$5,000 - $10,000	163,263	$1,174,379,690	$10,142,166
1.95%	$10,000 - $25,000	298,094	$5,024,186,915	$97,891,632
2.41%	$25,000 - $50,000	267,538	$9,556,088,464	$230,622,049
2.80%	$50,000 - $100,000	109,613	$7,104,157,256	$199,181,178
3.56%	$100,000 - Over	20,999	$5,402,912,601	$192,571,340
2.56%	Total	1,000,103	$28,621,609,498	$731,722,286