Approved 3-17-86
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Rep. Rex B. Hoy at
Chairperson

3:30 XX a.m./p.m. on March 6, 1986 in room 521-S of the Capitol.

All members were present except:

Rep. King, excused
Rep. Lowther, excused

Committee staff present:

Ms. Emalene Correll, Research Department
Ms. Melinda Hanson, Research Department
Mr. Gordon Self, Revisor's Office
Ms. Deanna Willard, Committee Secretary

Conferees appearing before the committee:

Ms. Lois Johnson, McDonald, Kansas
Ms. Linda Wright, Kansas Alzheimer's Disease Task Force
Ms. Ellen Zeckser, Huntington's Disease Foundation
Ms. Harriet Nehring, Kansans for Improvement of Nursing Homes
Ms. Wanda Blaser, Alzheimer's Disease Association
Sec. Joyce Romero, Department on Aging
Mr. Stephen Robertson, Health Insurance Assoc. of America
Mr. Walt Whalen, Pyramid Life

Final action on: HB 2496 - concerning misrepresentations relating to dental contracts

Rep. Littlejohn moved that HB 2496 be reported favorably. Rep. Bryant made a motion that a substitute bill be considered; Rep. Neufeld seconded the motion. The substitute bill broadens the provisions of the bill to make them applicable to dental hygienists, optometrists, pharmacists, podiatrists, physicians, and psychologists; this is accomplished by amending the enabling act for each of these professions into the substitute bill. (Attachment 1.)

Concern was expressed that a provider may get into a "catch 22" because of "deadbeats," but the consensus was that 14(A) and (B) would protect him if he turned in the claim in good faith. It was suggested that hygienists probably don't do any actual billing, so it might not be appropriate to include them in the amendment. Rep. Neufeld moved that the substitute bill be passed favorably; Rep. Blumenthal seconded the motion. The motion carried.

Hearing on: HB 3062 - disability income protection (Alzheimer's disease)

Hearing on: HB 3064 - concerning accident and sickness insurance; coverage for long-term care

The first conferee was Mrs. Lois Johnson, of McDonald, Kansas. She discussed problems that were encountered obtaining payment from their insurance company when her husband was diagnosed to have Alzheimer's. She stated that most insurance companies consider Alzheimer's to be a mental disease, which limits coverage to those for mental disease treatment. (Attachment 2.)

Ms. Melinda Hanson, Research Department, briefed the committee on HB 3062. It would provide that every insurer which issues any disability income protection policy (individual or group) include coverage for Alzheimer's to an equal degree to that provided for any other covered disability. The word "dimentia" on Line 0031 should be changed to "dementia."

Ms. Linda Wright, Alzheimer's Disease Task Force member, appeared next before the committee to urge support of the bill. She explained that the disease causes damage to the nerve cells of the brain and renders its victims unable to function in the workplace or home. She stressed that the damage is irreparable, and thus, rehabilitation is not an option. She discussed the special hardships on those families still dependent upon the affected individual for the support and rearing of children. She felt that support of the bill could remove the discrimination in insurance laws related to this disorder. (Attachment3.)

She was asked if there are other illnesses that are statutorily defined; she responded that Illinois has passed a bill similar to this one. She was asked if there is always a problem with the insurance coverage, and she said it is considered a mental disorder in most states and has been excluded because of its nature. There is no rehabilitation; it is progressive and long-term.

The next conferee, Ms. Ellen Zeckser, Huntington's Disease Foundation, gave a history of the disease. She said that some insurance companies explicitly exclude coverage for Huntington's, and most will not pay for non-treatable illness or custodial care. She cited instances when a person would not qualify for any financial assistance. She spoke of a 1977 Congressional Hearing which resulted in many recommendations for meeting the needs of Huntington's Disease victims, though few have been implemented. She presented the Chairman with a packet of letters from some persons closely associated with the disease which described their experiences. (Attachment 4.)

Ms. Harriet Nehring, Kansans for Improvement of Nursing Homes, was the next conferee. She reiterated the problem of Alzheimer's victims being excluded from insurance coverage because they are categorized as having mental illness, which she stated is unfair as medical research has established the origin as organic. (Attachment 5.)

Ms. Nehring also presented testimony on HB 3064. She said there is a real need for better long term health care coverage in Kansas. She identified several reasons for this need: 1) Medicare supplement policies often don't provide for long term care expense, though many citizens have a false impression that they do. Most policies apply to care in a skilled home, and most Kansas nursing homes are intermediate

care homes. Also, policies often supplement only maximum Medicare benefits; frequently a Medicare claim for long term care is denied, which negates the supplemental coverage. 2) There is a growing number of older people in the population. 3) Nursing home costs have escalated dramatically. 4) The shifting of federal programs to the states is stretching their capability to provide for the needs of their citizens. 5) The average length of a nursing home stay is about three years; however, Alzheimer's Disease takes an average of six years to run its course, and as about 40% of the population in intermediate care homes are victims of the disease, the need for longer terms is becoming apparent. 6) Inclusion of non-institutional long term care as a coverage is less costly and the preferred option of many people. (Attachment 6.)

The representative from the Department on Aging supported the figures given for the percentage of the nursing home population afflicted with Alzheimer's Disease.

The next conferee was Ms. Wanda Blaser, Alzheimer's Disease and Related Disorder's Association. She spoke in support of HB 3064 for the following reasons: 1) Current insurance policies reimburse for "acute care" and "rehabilitative potential," which do not apply to Alzheimer patients. 2) Progressive debilitating diseases deserve insurance reimbursement. 3) Coverage of community based long term care services may prevent acute care costs or premature nursing home placement. 4) Coverage of long term care needs may prevent the caregiver from overexerting to the point where he becomes a patient possibly in need of acute care insurance. (Attachment 7.)

Secretary Joyce Romero, Department on Aging, spoke in favor of HB 3064 as it would require all health care policies sold in the state to include an option for coverage of long-term care services, both in-home and institutional. She cited figures of the average annual nursing home costs and the breakdown of how they are paid. She said that these costs are affecting the poor and the middle class (many of whom will spend themselves into poverty within 13 weeks if stricken by chronic illness that requires long-term care.) Medicare, therefore, ends up paying for persons who would have been willing to make provision for their own long-term care needs. She stated that there are 30 insurance companies who offer coverages for long-term care--but none in Kansas. She suggested that some benefits of this bill are that it would preserve the dignity of elderly persons by giving them the opportunity to plan for their long-term health care needs, reduce the reliance upon public programs, and offer a new growth potential for the insurance industry. (Attachment 8.)

There was discussion as to why so many Alzheimer's diagnoses are being missed. There are other diseases that mimic it, and it is diagnosed by the process of elimination. A brain

biopsy would not even guarantee an accurate diagnosis, and as there is no treatment, it isn't prudent to put people through the test.

The next conferee, Mr. Stephen Robertson, Health Insurance Association of America, appeared in opposition to HB 3064. Mr. Robertson stated that long-term care means more than a nursing home stay; it represents a complex area of services, the cost of which is an emerging concern of the elderly. The purchase of private insurance is one way to relieve the growing pressure on family resources caused by long-term care needs. He discussed the various types of policies currently being offered and the different benefit levels: skilled, intermediate, custodial, and home care. He explained why benefits are designed this way, which included giving patients reason to find efficient providers who can supply needed care within the benefit level, limiting an insurer's liability under any one policy, and somewhat reducing the risk of providing the insurance. He stated that insurance must clearly define the risk covered and seek to provide coverage designed to avoid anti-selection. He discussed the difficulty of designing and underwriting these products. He mentioned that the National Association of Insurance Commissioners and the association which he represents are developing recommendations in the area of long-term care insurance, which are expected by the fall of 1986. He concluded that long-term care insurance is in an embryonic stage and that the challenge is for insurers to establish benefit levels and premium charges in products which minimize insurance-induced demand for services and adverse selection, which avoid stimulating increased provider charges, and which provide meaningful benefits to consumers. (Attachment 9.)

Mr. Walt Whalen, Pyramid Life, spoke in opposition to HB 3062. He stated that, to his knowledge, most companies recognize Alzheimer's Disease as physical. He stated that no diseases are excluded from coverages for disability income, except for "pre-existing" conditions. He felt that the problem stems from the difficulty in receiving a diagnosis and stated that insurance companies should not be blamed for what is a problem of the medical field. He discussed types of disability income policies, the fact that they are issued for a set term, i.e. one year, three years, life. The premium paid depends on the length of time for which one is seeking reimbursement for lost income. He stressed that these policies are designed to replace income, not to pay medical expenses while one is disabled. He would like for the bill to clarify that disability income would be provided when the insured is unable to work, which in this case might not be right at the time he is diagnosed. He said that policies are available for all levels of care, which are rated on the age of the applicant. A committee member requested availability and affordability figures for this type of coverage.

The minutes of the previous meeting were approved as amended.

The meeting was adjourned at 5:07 by the Chairman.

GUEST LIST

COMMITTEE: Insurance DATE: 3-6-86

NAME	ADDRESS	COMPANY/ORGANIZATION
Lyndon Drew	Topeka	KDOA
Val Braun	"	Ks Med Soc
Marsha Hutchison	Topeka	KMS
Joyce Romero	"	KDOA
Jackie Weber	"	"
Marlene Hoglund	"	KDOA
Grace Wilson	"	Active Aging Wichita, Ks
Wanda Blaser	"	ADRDA Topeka
Linda Wright	Prairie Village	ADRDA-JoCo
Barbara Daley	Topeka	Alzheimer's Support Group
Lois Johnson	McDonald, Ks	alzheimer "Family"
Harriet Nehring	Lawrence	KINH
Ellen Zuckser	Topeka	Huntington Disease Foundation of America
George Goebel	Topeka	State Coordinator AARP
Lee WRIGHT	MISSION	FARMERS INS. GROUP
Wayne Mannis	Topeka	Security Benefit Life
Tom Rosselot	Topeka	Kansas State Nurses Assoc.
Diane Baltaff	Topeka	ADRDA - Topeka Chapter
Dick Brock	"	Ins. Dept.
John Grace	"	KS Homes for Aging
Carl Schmitthenner	"	Kansas Dental Association
Ken Schafermeyer	"	KS Pharmacists Assoc.
JACK ROBERTS	"	BC-BS
Stephen W. Robertson	Des Plaines Ill	Health Ins Assn. of Am.
Richard Harmon	Topeka	KS Life Assoc.
W.W. Whalen	Mission	Bymm & Life
Michael Gee	Kansas City	Kansas Pharmacy Assoc.

Proposed Substitute for HOUSE BILL NO. 2496

AN ACT concerning certain health care providers; relating to certain misrepresentations concerning insurance contracts; amending K.S.A. 65-1436, 65-1506, 65-1627, 65-2006, 65-2836 and 74-5324 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-1436 is hereby amended to read as follows: 65-1436. (a) The Kansas dental board may refuse to issue the license provided for in this act, or may take any of the actions with respect to any dental or dental hygiene license as set forth in subsection (b), whenever it is established, after notice and opportunity for hearing in accordance with the provisions of the Kansas administrative procedure act, that any applicant for a dental or dental hygiene license or any licensed dentist or dental hygienist practicing in the state of Kansas has:

(1) Committed fraud, deceit or misrepresentation in obtaining any license, money or other thing of value;

(2) committed gross immorality;

(3) habitually used intoxicants or drugs which have rendered such person unfit for the practice of dentistry or dental hygiene;

(4) been determined to be incompetent;

(5) committed gross, wanton or willful negligence in the practice of dentistry or dental hygiene;

(6) employed, allowed or permitted any unlicensed person or persons to perform any work in the licensee's office which constitutes the practice of dentistry or dental hygiene under the provisions of this act;

(7) willfully violated the laws of this state relating to the practice of dentistry or dental hygiene or the rules and

regulations of the secretary of health and environment or of the board regarding sanitation;

(8) engaged in the division of fees, or agreed to split or divide the fee received for dental service with any person for bringing or referring a patient without the knowledge of the patient or the patient's legal representative, except the division of fees between dentists practicing in a partnership and sharing professional fees, or in case of one licensed dentist employing another;

(9) committed complicity in association with or allowed the use of the licensed dentist's name in conjunction with any person who is engaged in the illegal practice of dentistry;

(10) been convicted of a felony if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust, or a misdemeanor involving moral turpitude;

(11) failed to pay license fees;

(12) used the name "clinic," "institute" or other title that may suggest a public or semipublic activity except that the name "clinic" may be used as authorized in K.S.A. 65-1435 and amendments thereto; ~~or~~

(13) committed, after becoming a licensee, any conduct which is detrimental to the public health, safety or welfare as defined by rules and regulations of the board~~.~~; or

(14) engaged in a misleading, deceptive, untrue or fraudulent misrepresentation in the practice of dentistry or on any document connected with the practice of dentistry by:

(A) Knowingly submitting any misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement to a third-party payer;

(B) knowingly submitting a claim form, bill or statement asserting a fee for any given dental appliance, procedure or service rendered to a patient covered by a dental insurance plan, which fee is greater than the fee the dentist usually accepts as payment in full for any given dental appliance, procedure or service;

(C) abrogating the copayment provisions of a contract by accepting the payment received from a third-party payer as full payment, if the claim, bill or statement submitted for payment violates the provisions of (14)(A) or (14)(B).

(b) Whenever it is established, after notice and opportunity for hearing in accordance with the provisions of the Kansas administrative procedure act, that a licensee is in any of the circumstances or has committed any of the acts described in subsection (a), the Kansas dental board may take one or any combination of the following actions with respect to the license of the licensee:

(1) Revoke the license.

(2) Suspend the license for such period of time as may be determined by the board.

(3) Restrict the right of the licensee to practice by imposing limitations upon dental or dental hygiene procedures which may be performed, categories of dental disease which may be treated or types of patients which may be treated by the dentist or dental hygienist. Such restrictions shall continue for such period of time as may be determined by the board, and the board may require the licensee to provide additional evidence at hearing before lifting such restrictions.

(4) Grant a period of probation during which the imposition of one or more of the actions described in subsections (b)(1) through (b)(3) will be stayed subject to such conditions as may be imposed by the board including a requirement that the dentist or dental hygienist refrain from any course of conduct which may result in further violation of the dental practice act or the dentist or dental hygienist complete additional or remedial instruction. The violation of any provision of the dental practice act or failure to meet any condition imposed by the board as set forth in the order of the board will result in immediate termination of the period of probation and imposition of such other action as has been taken by the board.

(c) The board may upon its own motion or upon the request of any licensee who is a party to a licensure action require a

physical or mental examination, or both, of such licensee either prior to a hearing to be held as a part of a licensure action or prior to the termination of any period of suspension or the termination of any restrictions imposed upon the licensee as provided in subsection (b).

Sec. 2. K.S.A. 65-1506 is hereby amended to read as follows: 65-1506. (a) The board may suspend or revoke the license of any optometrist for any one of the following causes:

(1) Conviction of the accused of any crime of the grade of felony, or one which involved moral turpitude;

(2) any form of fraud or deceit used in securing a license;

(3) the obtaining of any fee by fraud or misrepresentation;

(4) the employing or using, either directly or indirectly, of any person or persons with or without payment to direct or obtain patients for such optometrist;

(5) professional incompetence;

(6) the employment of any person not licensed to perform the work covered by this act;

(7) to advertise in any way in an unethical manner;

(8) the use of unauthorized drugs in the examination or treatment of the eyes;

(9) for habits of intemperance or habitual drunkenness or addiction to the drug habit;

(10) failure to actively practice optometry for a period of three consecutive years;

(11) for any cause for which the optometry board might refuse to admit a candidate to their examinations; ~~or~~

(12) for the violations of any of the provisions of this act or the rules and regulations and code of ethics adopted by the board~~.~~; or

(13) (A) knowingly submitting any misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement to a third-party payer;

(B) knowingly submitting a claim form, bill or statement asserting a fee for any given service rendered to a patient covered by an insurance plan, which fee is greater than the fee

the optometrist usually accepts as payment in full for any given service;

(C) abrogating the copayment provisions of a contract by accepting the payment received from a third-party payer as full payment, if the claim, bill or statement submitted for payment violates the provisions of (13)(A) or (13)(B).

(b) The board shall not suspend, revoke or refuse to renew any license of any optometrist without first complying with the notice and hearing requirements of the Kansas administrative procedure act.

Sec. 3. K.S.A. 65-1627 is hereby amended to read as follows: 65-1627. (a) The board may revoke, suspend, place in a probationary status or deny a renewal of any registration of any pharmacist upon a finding that:

(1) The registration was obtained by fraudulent means;

(2) the registrant has been convicted of felony and the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust;

(3) the registrant is found by the board to be guilty of gross immorality;

(4) the registrant is addicted to the liquor or drug habit to such a degree as to render the registrant unfit to practice the profession of pharmacy;

(5) the registrant has violated a provision of the federal or state food, drug and cosmetic act;

(6) the registrant is found by the board to have filled a prescription not in strict accordance with the directions of the practitioner;

(7) the registrant is found to be mentally or physically incapacitated to such a degree as to render the registrant unfit to practice the profession of pharmacy;

(8) the registrant has violated any of the provisions of the pharmacy act of the state of Kansas or any rule and regulation adopted by the board pursuant to the provisions of such pharmacy act;

(9) the registrant has failed to comply with the

requirements of the board relating to the continuing education of pharmacists; ~~or~~

(10) the registrant as a pharmacist in charge or consultant pharmacist under subsection (c) or (d) of K.S.A. 65-1648 and amendments thereto has failed to comply with the requirements of subsection (c) or (d) of K.S.A. 65-1648 and amendments thereto~~.~~; or

(11) the registrant has:

(A) Knowingly submitted a misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement to a third-party payer;

(B) knowingly submitted a claim form, bill or statement asserting a fee for any given service rendered to a patient covered by an insurance plan, which fee is greater than the fee such registrant usually accepts as payment in full for any given service;

(C) abrogated the copayment provisions of a contract by accepting the payment received from a third-party payer as full payment, if the claim, bill or statement submitted for payment violates the provisions of (11)(A) or (11)(B).

(b) The board may suspend, revoke, place in a probationary status or deny a renewal of any retail dealer's permit issued by the board when information in possession of the board discloses that such operations for which the permit was issued are not being conducted according to law or the rules and regulations of the board.

(c) The board may revoke, suspend, place in a probationary status or deny a renewal of the registration of a pharmacy upon a finding that: (1) Such pharmacy has been operated in such manner that violations of the provisions of the pharmacy act of the state of Kansas or of the rules and regulations of the board have occurred in connection therewith; (2) the owner or any pharmacist employed at such pharmacy is convicted, subsequent to such owner's acquisition of or such employee's employment at such pharmacy, of a violation of the pharmacy act or uniform controlled substances act of the state of Kansas, or the federal

or state food, drug and cosmetic act; or (3) the owner or any pharmacist employed by such pharmacy has fraudulently claimed money for pharmaceutical services.

(d) A registration to manufacture or to distribute at wholesale a drug or a registration for the place of business where any such operation is conducted may be suspended, revoked, placed in a probationary status or the renewal of such registration may be denied by the board upon a finding that the registrant or the registrant's agent: (1) Has materially falsified any application filed pursuant to or required by the pharmacy act of the state of Kansas; (2) has been convicted of a felony under any federal or state law relating to the manufacture or distribution of drugs; (3) has had any federal registration for the manufacture or distribution of drugs suspended or revoked; (4) has refused to permit the board or its duly authorized agents to inspect the registrant's establishment in accordance with the provisions of K.S.A. 65-1629 and amendments thereto; or (5) has failed to keep, or has failed to file with the board or has falsified records required to be kept or filed by the provisions of the pharmacy act of the state of Kansas or by the board's rules and regulations.

(e) All proceedings pursuant to this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act and the act for judicial review and civil enforcement of agency actions.

Sec. 4. K.S.A. 65-2006 is hereby amended to read as follows: 65-2006. (a) The board, upon hearing, may revoke, suspend or limit any license or permit to practice podiatry, or may deny issuance or renewal of any such license or permit, if the person holding or applying for such license or permit is found by the board to:

(1) Have committed fraud in securing the license or permit;

(2) have engaged in immoral, unprofessional or dishonorable conduct or professional incompetency;

(3) have been convicted of a felony if the board determines, after investigation, that such person has not been sufficiently

rehabilitated to warrant the public trust;

(4) have used untruthful or improbable statements or flamboyant, exaggerated or extravagant claims in advertisements concerning the licensee's or permit holder's professional excellence or abilities;

(5) have used or distributed literature advertising professional abilities;

(6) have used any other unethical advertising practice;

(7) be addicted to or have distributed intoxicating liquors or drugs for any other than lawful purposes;

(8) have willfully or repeatedly violated the podiatry act, the pharmacy act or the uniform controlled substances act, or any rules and regulations adopted thereunder, or any rules and regulations of the secretary of health and environment which are relevant to the practice of podiatry;

(9) have unlawfully invaded the field of practice of any branch of the healing arts;

(10) have failed to pay annual renewal fees specified in this act;

(11) have failed to submit proof of completion of a continuing education course required pursuant to the podiatry act;

(12) have engaged in the practice of podiatry under a false or assumed name or impersonated another podiatrist, but practice by a licensee or permit holder under a professional corporation or other legal entity duly authorized to provide podiatry services in the state shall not be considered to be practice under an assumed name;

(13) be unable to practice podiatry with reasonable skill and safety to patients by reason of any mental or physical condition, illness, alcoholism or excessive use of drugs, controlled substances or chemical or any other type of material;

(14) have had their license or permit to practice podiatry revoked, suspended or limited, or have had other disciplinary actions taken or an application for a license or permit denied, by the proper licensing authority of any state, territory or

country or the District of Columbia; ~~or~~

(15) have violated any rules and regulations of the board or any lawful order or directive of the board~~.~~; or

(16) have (A) knowingly submitted a misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement to a third-party payer;

(B) knowingly submitted a claim form, bill or statement asserting a fee for any given service rendered to a patient covered by an insurance plan, which fee is greater than the fee such person usually accepts as payment in full for any given service;

(C) abrogated the copayment provisions of a contract by accepting the payment received from a third-party payer as full payment, if the claim, bill or statement submitted for payment violates the provisions of (16)(A) or (16)(B).

(b) In determining whether or not a licensee or permit holder is unable to practice podiatry with reasonable skill and safety to patients as provided in subsection (a)(13), the board, upon probable cause, shall have authority to compel a licensee or permit holder to submit to mental or physical examination by such persons as the board may designate. Failure of a licensee or permit holder to submit to such examination when directed shall constitute an admission of the allegations against the licensee or permit holder, unless the failure was due to circumstances beyond the licensee's or permit holder's control. A person affected by this subsection shall be offered, at reasonable intervals, an opportunity to demonstrate that such person can resume the competent practice of podiatry with reasonable skill and safety to patients. Each licensee or permit holder accepting the privilege to practice podiatry in this state, by practicing podiatry in this state or by making and filing an application for a license or permit, or renewal of a license or permit, to practice podiatry in this state, shall be deemed to have consented to submit to a mental or physical examination when directed in writing by the board pursuant to this subsection and to have waived all objections to the admissibility of the

testimony or examination report of the person conducting such examination at any proceeding or hearing before the board on the ground that such testimony or examination report constitutes a privileged communication. The record of any board proceedings involving a mental or physical examination pursuant to this subsection shall not be used in any other administrative or judicial proceeding.

Whenever the board directs that a licensee or permit holder submit to an examination pursuant to this subsection, the time from the date of the board's directive until the submission to the board of the report of the examination shall not be included in the computation of the time limit for hearing prescribed by K.S.A. 65-2842 and amendments thereto.

(c) As used in this section, "professional incompetency" and "unprofessional conduct" shall have the meanings ascribed thereto by K.S.A. 65-2837 and amendments thereto.

(d) The procedure for revocation, suspension, limitation, temporary suspension, temporary limitation, or for denial of issuance or renewal pursuant to this section, of any license or permit to practice podiatry shall be in accordance with the provisions of the Kansas administrative procedure act.

Sec. 5. K.S.A. 65-2836 is hereby amended to read as follows: 65-2836. A license may be revoked, suspended or limited when the licensee has been found to have committed any of the following acts:

(a) Fraud in securing the license.

(b) Immoral, unprofessional or dishonorable conduct or professional incompetency.

(c) Conviction of a felony if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust.

(d) Use of fraudulent or false advertisements.

(e) Addiction to or distribution of intoxicating liquors or drugs for any other than lawful purposes.

(f) Willful or repeated violation of this act, the pharmacy act of the state of Kansas or the uniform controlled substances

act, or any rules and regulations adopted pursuant thereto, or any rules and regulations of the secretary of health and environment which are relevant to the practice of the healing arts.

(g) Unlawful invasion of the field of practice of any branch of the healing arts in which the licensee is not licensed to practice.

(h) Failure to pay annual renewal fees specified in this act.

(i) Failure to take some form of postgraduate work each year or as required by the board.

(j) Engaging in the practice of the healing arts under a false or assumed name, or the impersonation of another practitioner. The provisions of this subsection relating to an assumed name shall not apply to licensees practicing under a professional corporation or other legal entity duly authorized to provide such professional services in the state of Kansas.

(k) Inability to practice the branch of the healing arts for which such person is licensed with reasonable skill and safety to patients by reason of illness, alcoholism, excessive use of drugs, controlled substances, chemical or any other type of material or as a result of any mental or physical condition. In determining whether or not such inability exists, the board, upon probable cause, shall have authority to compel a licensee to submit to mental or physical examination by such persons as the board may designate. The licensee shall submit to the board a release of information authorizing the board to obtain a report of such examination. Failure of any licensee to submit to such examination when directed shall constitute an admission of the allegations against the licensee, unless the failure was due to circumstances beyond the control of the licensee, and the board may enter a default and final order in any case of default without just cause being shown to the board without the taking of testimony or presentation of evidence. A person affected by this subsection shall be offered, at reasonable intervals, an opportunity to demonstrate that such person can resume the

competent practice of the healing arts with reasonable skill and safety to patients. For the purpose of this subsection, every person licensed to practice the healing arts and who shall accept the privilege to practice the healing arts in this state by so practicing or by the making and filing of an annual renewal to practice the healing arts in this state shall be deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the testimony or examination report of the person conducting such examination at any proceeding or hearing before the board on the ground that such testimony or examination report constitutes a privileged communication. In any proceeding by the board pursuant to the provisions of this subsection, the record of such board proceedings involving the mental and physical examination shall not be used in any other administrative or judicial proceeding.

(l) Had a license to practice the healing arts revoked, suspended, or limited or had other disciplinary action taken, or an application for a license denied, by the proper licensing authority of another state, territory, District of Columbia, or other country.

(m) Violated any lawful rule or regulation promulgated by the board or violated any lawful order or directive of the board previously entered by the board.

(n) Failure to report or reveal the knowledge required to be reported or revealed under K.S.A. 65-28,122 and amendments thereto.

(o) Failure by persons licensed to practice medicine and surgery to inform a patient suffering from any form of abnormality of the breast tissue for which surgery is a recommended form of treatment, of alternative methods of treatment specified in the standardized summary supplied by the board. The standardized summary shall be given to each patient specified herein as soon as practicable and medically indicated following diagnosis, and this shall constitute compliance with the requirements of this subsection (o). The board shall develop

and distribute to persons licensed to practice medicine and surgery a standardized summary of the alternative methods of treatment known to the board at the time of distribution of the standardized summary, including surgical, radiological or chemotherapeutic treatments or combinations of treatments and the risks associated with each of these methods. Nothing in this subsection (o) shall be construed or operate to empower or authorize the board to restrict in any manner the right of a person licensed to practice medicine and surgery to recommend a method of treatment or to restrict in any manner a patient's right to select a method of treatment. The standardized summary shall not be construed as a recommendation by the board of any method of treatment. The preceding sentence or words having the same meaning shall be printed as a part of the standardized summary. The provisions of this subsection (o) shall not be effective until the standardized written summary provided for in this subsection (o) is developed and printed and made available by the board to persons licensed by the board to practice medicine and surgery.

(p) (1) Knowingly submitting any misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement to a third-party payer;

(2) knowingly submitting a claim form, bill or statement asserting a fee for any given service rendered to a patient covered by an insurance plan, which fee is greater than the fee such person usually accepts as payment in full for any given service;

(3) abrogating the copayment provisions of a contract by accepting the payment received from a third-party payer as full payment, if the claim, bill or statement submitted for payment violates the provisions of (p)(1) or (p)(2).

Sec. 6. K.S.A. 74-5324 is hereby amended to read as follows: 74-5324. The certificate of any psychologist may be suspended or revoked by the board upon proof that the psychologist: (a) Has been convicted of a felony involving moral turpitude; ~~or~~

(b) has been guilty of fraud or deceit in connection with

~~his~~ services rendered as a psychologist or in establishing ~~his~~ qualifications under this act; ~~or~~

(c) has aided or abetted a person, not a certified psychologist, in representing ~~himself~~ such person as a psychologist in this state; ~~or~~

(d) has been guilty of unprofessional conduct as defined by rules and regulations established by the board; ~~or~~

(e) has been guilty of negligence or wrongful actions in the performance of ~~his~~ such psychologist's duties~~.~~; or

(f) has (1) knowingly submitted a misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement to a third-party payer;

(2) knowingly submitted a claim form, bill or statement asserting a fee for any given service rendered to a patient covered by an insurance plan, which fee is greater than the fee the psychologist usually accepts as payment in full for any given service;

(3) abrogated the copayment provisions of a contract by accepting the payment received from a third-party payer as full payment, if the claim, bill or statement submitted for payment violates the provisions of (f)(1) or (f)(2).

Sec. 7. K.S.A. 65-1436, 65-1506, 65-1627, 65-2006, 65-2836 and 74-5324 are hereby repealed.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

TESTIMONY ON H.B. 3062
BY LOIS JOHNSON, MCDONALD, KANSAS
MARCH 6, 1986

Representative Hoy and Committee Members:

I support bill 3062

My husband was 49 when he was diagnosed with Alzheimer's. I would like to testify to the problems we encountered obtaining payment from our insurance company with the diagnosis "Alzheimer's". To most of the insurance companies, Alzheimer's is a mental disease, thereby limiting the coverage to their regulations, usually 90 days inpatient and no outpatient. Most all policies offer no long term care for Alzheimer's patients.

We were refused payment on our major medical insurance because the local doctor wrote "Alzheimer check-up" on the billing. After I sent copies of the doctor's new diagnosis of organic brain syndrome, probably Alzheimer's, payment was made.

I feel all insurance companies should recognize Alzheimer's for the physical disease it is, and offer insurance accordingly.

Thank you.

Attachment 2
House Insurance/3-6-86

RE: HOUSE BILL NO. 3062

Testimony before Kansas House Insurance Committee

Submitted by: Linda Wright
Member, Kansas Alzheimer's Disease Task Force
Past Chairman, Greater Kansas City Area Chapter
Alzheimer's Disease & Related Disorders Association (ADRDA)
Advocacy Chairman, Greater Kansas City Area Chapter
ADRDA

As a member of the Kansas Alzheimer's Disease Task Force and as a member of the Greater Kansas City Area Chapter of ADRDA, I would like to encourage this committee's support of House Bill 3062.

Alzheimer's disease is an illness which is chronic and debilitating in its nature. The damage to the nerve cells (neurons) of the brain of these individuals renders them disabled in such a way that they are unable to function in the workplace, home or community. One of the body's most vital organs, the brain, is irreparably damaged. Rehabilitation is not an option, with persons affected by this and like disorders. Their disability and impaired function can be observed in a very real way.

Alzheimer's disease is not a psychiatric disorder even though there are unusual and difficult behaviors involved. This illness places tremendous physical and financial burden upon the families who care for them. While the impact of this is felt whether the disabled person is 45 or 65, it does pose special hardships for those families still dependent upon the affected individual for major financial contribution to the support and rearing of children. Additionally, caregivers themselves become impoverished and ill as they are unable to work, butinstead must give 24-hour care to their disabled person.

Support of this bill could remove the discrimination which exists today against those affected by Alzheimer's and related disorders.

Attachment 3
House Insurance
3-6-86

HUNTINGTON'S DISEASE

In 1872, a 21 year old medical school graduate named George Huntington described a strange disease at a medical conference in New England. We now believe that that ailment known as Huntington's Disease existed even in the Middle Ages. Huntington's Disease causes its victims to writhe, twist , jerk and turn in constant uncontrollable movement, and we believe H. D. was a factor in the Salem Witch Trials.

There is little more treatment today for this 15 to 20 year disease than existed in 1872. Nor is there a predictive test for H. D.

Incidents rates may be as high as 10 in 100,000 and approximately twice the number of patients are at risk.

Families affected by Huntington's Disease lose income if the patient is bread-winner, or must pay for domestic help and child care if the homemaker falls ill. Home care must be paid for, or institutional costs are incurred for upwards of 20 years. At the current price of $12,7000 yearly for nursing home care, costs can mount to $200,000 over fifteen years. The costs of long rerm care for H. D. patients are so high, that health agency personnel often advise the healthy spouse to get a divorce so that the patient can become eligible for medical benefits or become a ward of the state.

Attachment 4
House Insurance
3-6-86

Tragically, this may be the only way the well spouse can attempt to meet the needs of children at risk and to put resources aside for the care of children who, indeed, inherit the disease.

While the direct cost for long term care has been described, this does not include productivity lost to family and society, cost of extra housekeeping , special food, clothing , safety devices, aids to the handicapped, rehabilitation and other services. This also does not include the price of social and emotional upheaval which can lead to additional medical and psychotherapy osts for family members.

Private medical insurance rarely pays long-term costs. Some insurance companies explicitly excludes coverage for Huntington's Disease. Most will not pay for non-treatable illness or custodial care.

Disability Insurace under Title II of the Social Security Act provides some financial assistance for wage earners. To qualify, certain work criteria must be satisfied. Because the onset of H. D. is insidious, many patients have an irregular work history and do not qualify. Women with chronic disease who are homemakers are inelligible because their labor in the home has not been for wages.

In 1977 a U. S. Congressional Hearing was conducted which resulted in many recommendations for meeting the needs of those victimized by Huntington's Disease. Very few of those recommendations have been implemented. It is my hope that this committee will successfully bring these proposed bills to completion.

Respectfully submitted,

Ellen Zeckser, vice president HDFA KS Chpt. Topeka, Branch

Ellen Zeckser

2007 N. Monroe

Topeka, Ks. 66608

Taken from
Commission report p. 177
- Figures and information is still correct.

SUMMARY

The Disease

The fear of losing one's mind and the fear of losing control over one's body are among the most profound fears known to mankind. Both losses occur in Huntington's disease, a hereditary and terminal brain disorder which begins insidiously, usually in middle age. Men and women affected grow irritable or hostile; their personalities change. Some become manic, some apathetic, some suicidally depressed. Powers of reason, memory, and judgment fade, leading inevitably to dementia.

Physical symptoms accompany the mental changes. Patients may appear clumsy or fidgety at first. They may grimace or smile in a peculiar way. As the disease progresses they may have difficulty in talking or swallowing; they lose control over normal body functions. Their restless movements become exaggerated and incessant. They twist, writhe and lurch; they make flailing movements of head, trunk or limbs, ever on the verge of falling.

Those symptoms describe what Huntington's disease looks like in someone who has struggled 10 or 20 years with it. It may explain why a woman now known to have had Huntington's disease was hanged as a witch in 17th century Salem. Or why the late composer and folk singer, Woody Guthrie, was considered an alcoholic and was in and out of mental hospitals for years before the true diagnosis of Huntington's disease was made.

Atch. to
Atch. 4
H. Ins. 3/6/86

a.

MORE ABOUT HUNTINGTON'S DISEASE AND ITS CONSEQUENCES

Inheritance - Each child of a parent with Huntington's disease has a 50-50 chance of inheriting the disorder. There is no way of knowing who has inherited the gene for Huntington's disease until the symptoms appear.

Age of Onset - The usual time of onset is between 35 and 45, but about 10 percent of cases occur in young people under 20. Children as young as two and adults as old as 80 have been known to develop the disease. People who are "at risk"--who have a parent with the disease--may have to wait a lifetime to know if they have been spared.

Diagnosis - Huntington's disease is usually diagnosed on the basis of the characteristic uncontrollable movements, called chorea (from the Greek word for dance), and a family history. Mood or personality changes and minor movements may precede diagnosis by 10 years or more. Some patients show more severe mental symptoms; others have more severe movement problems.

Prognosis - Huntington's disease is chronic, progressive, and terminal, taking its toll over a 10- to 20-year period. There are no states of remission as in multiple sclerosis or some cases of cancer. The disease is usually more severe in children. There is some evidence that the later the disease appears, the milder is its course.

Death - Cause of death in Huntington's patients is commonly heart failure, pneumonia, or other infections following an exhausting siege of illness. Accidental death from falls or death from choking, because of difficulties in chewing or swallowing, are also frequent.

Treatment - There is no effective treatment for Huntington's disease. Some medications used in treating schizophrenia provide some relief for the abnormal movements. Other drugs may relieve some of the symptoms of depression or other mood disturbances. No drug can treat the loss of mental faculties. All drugs provide only partial relief in some people for limited times only.

Suicide - There is a high suicide rate among Huntington's disease patients and those at risk. Some authorities estimate it is seven times the national suicide rate--1.3 percent of all deaths in the United States.

Prevalence - No reliable figures are available on the incidence or prevalence of Huntington's disease. Patients often are misdiagnosed as schizophrenic, or as suffering from Parkinson's disease or other neurologic disorders. Death certificates frequently do not

record Huntington's disease as a cause of death. Some families also hide the existence of the disease out of shame, fear, or guilt. Current estimates put prevalence rates in the range of four to seven per 100,000, although some recent studies suggest it may be as high as 10 in 100,000. Approximately twice the number of patients are at risk for the disorder.

Financial Cost - Families affected by Huntington's disease lose income if the patient is the breadwinner, or must pay for domestic help and child care if the homemaker falls ill. They must pay for home care or institutional costs for upwards of 20 years. At the current price of $12,700 a year for nursing home care, costs can mount to $200,000 over 15 years. The costs of long-term care for Huntington's disease patients are so high that health agency personnel sometimes advise the healthy spouse to get a divorce so that the patient can become a ward of the state and become eligible for medical benefits. Tragically, that may be the only way the well spouse can attempt to save to meet the future needs of children at risk.

Huntington's disease is a family disease. Every member of the family is affected--emotionally, physically, socially--whether patient, at risk, or spouse. And the disease occurs not once, but over and over again in successive generations.

Alzheimer's Disease and Related Disorders Association
TOPEKA CHAPTER

P.O. BOX 1427
TOPEKA, KS 66601

February 28, 1986

Dear Friends:

Now is the time to let our legislators know that Alzheimer's and the similar diseases are devastating to families, friends and the victims. There are now 6 bills dealing with Alzheimer's and related diseases before the legislature. It is very important that every one of you contact your legislators. If passed, these bills will lead to help for victims and families of Alzheimer's and similar diseases.

You must act fast because time is short. These bills must be passed out of the house of origin by March 12. Hearings might occur during the next two weeks. As soon as you receive this letter, please take action.

Please telephone all the interested and concerned people you know and pass on this important information to them. Not everyone will receive this letter. YOU CAN MAKE A DIFFERENCE.

Step One: Contact the legislators on the committees considering the bills (see enclosed) and ask for a hearing. Tell these legislators you support the bills. You can call 1-800-432-3924 to leave a message for a legislator.

Step Two: Find out if and when the committee will hear testimony on any of these bills. Hearings for 2 of the bills have been scheduled. The hearing is Wednesday, March 5, 1986 on S.B. 690 and on S.B. 691 (See enclosed). You can call 1-800-432-3924 to check the status of a bill and find out a hearing schedule.

Step Three: Come to the hearings. Even if you do not want to give testimony, show your support of the bill by your presence.

Step Four: Contact your own legislators and tell them you support these bills and urge them to support these bills.

If you are presenting testimony, you must contact the chair of the committee in advance to get on the agenda. Bring at least one copy of your testimony for the committee chairman. If possible, bring enough copies for all the committee members.

Organize your testimony to include information about the need and why this bill is a good solution to the problem. Give personal examples of how the bill affects you. A 3-5 minute presentation is ideal. Try to keep it to this length.

Remember that the legislature is considering several ways to raise revenue such as state lottery and a 1% sales tax increase. If legislators want to know how you would suggest financing these bills, you may wish to point out that some of the new revenue could fund the Alzheimer's bills.

If you cannot come, at least call the legislators on the committee and your legislators to tell them that you support the bill. (Call 1-800-432-3924 to leave messages for legislators.)

We hope that you will help in getting these bills passed. Your help is essential in getting relief for the caregivers and victims of Alzheimer's, Huntington's, Parkinson's and related diseases.

If you have additional questions, you may call Barbara Daley (913-862-2092) or Diane Bottorff (913-234-0421 - day; 913-273-7131 - evening) for information.

Sincerely,

Barbara L. Daley
ADRDA Support Group
Topeka Chapter

Diane Bottorff, R.N.
ADRDA Support Group
Topeka Chapter

Wanda Blaser, R.N., President
ADRDA Support Group
Topeka Chapter

Linda Wright, R.N. Advocacy Chair
ADRDA Support Group
Greater Kansas City Chapter

Keith Bossler, Vice-President
ADRDA Support Group
Topeka Chapter

Evelyn Sidner
ADRDA Support Group
Great Kansas City Chapter

Robert C. Guthrie, Advocacy Chair
ADRDA Support Group
Topeka Chapter

Enclosures: Information on Alzheimer's Bills
Information on committee members.

ALZHEIMER'S LEGISLATION
1986 KANSAS LEGISLATURE

1. Division of Assets (House Bill 3063) - The bill is modeled on regulations implemented in Colorado in 1979. Family assets would be split in half so that victims could qualify for medical assistance by spending down their half of family assets. Spouses with incomes below the median would be protected from recovery of support for nursing home care. (Referred to House Judiciary Committee.)

2. Long Term Care Insurance (House Bill 3064)- The bill requires insurance companies to offer long term care insurance for intermediate care in nursing homes and alternative services in the community including adult day care, respite, homemaker, home health aide, and case management. (Referred to House Insurance Committee.)

3. Respite Care (House Bill 3051)- The bill uses model legislation proposed by the Older Women's League. The Kansas Department on Aging would ensure the provision or coordination of the following services: in-home respite care, adult day care, short-term in-patient respite care, emergency respite care, peer support groups for caregivers, counseling services, educational programs, and case management. (Referred to House Public Health and Welfare Committee.)

4. Helpline (Senate Bill 690) - The bill authorizes the Kansas Department on Aging to establish an information and referral service on Alzheimer's Disease through the existing statewide toll-free telephone system and through local area agencies on aging. (Referred to Senate Public Health and Welfare Committee.)

5. Multidisciplinary Centers (Senate Bill 691) - The bill authorizes the creation of three medical centers for diagnosis, education and training, and psychosocial research. The University of Kansas Medical School would serve as one of the centers. Teaching and demonstration units would be established in both nursing homes and adult day care centers. (Referred to Senate Public Health and Welfare Committee.)

6. Medical Disability Insurance Policies (House Bill 3062) - The bill requires disability insurance policies to cover Alzheimer's and related diseases as disabilities. Alzheimer's and related diseases are defined. (Referred to House Insurance Committee.)

LEGISLATIVE INFORMATION

HELP IS AVAILABLE. There are a number of sources of help available, at little or no cost, for keeping track of legislation being considered by the Kansas Legislature. While not a comprehensive list, a number of the more useful sources are listed in the following paragraphs.

enclosed

DIRECTORIES. Several very useful legislative directories are available free just for the asking. The Legislative Directory, published by the Secretary of State (Room 234-N, State House, Topeka 66612, 913/296-2236), includes the home and business addresses of each legislator, along with his or her occupation and spouse's name. The directory also includes the party affiliation and district number for each legislator. The Division of Legislative Administrative Services (Room 511-S, State House, Topeka 66612, 913/296-2391) publishes the Legislative Telephone Directory, which gives the room and telephone number for the State House office of each legislator. The Division also publishes Legislative Staff Serving the Kansas Legislature, which lists the legislative leadership's administrative assistants, as well as the members of the Legislature's staff agencies and designates the subject matter specialties of each member of the Legislative Research Department and the Revisor of Statutes Office.

BILLS AND OTHER DOCUMENTS. Copies of all bills and a variety of other documents can be picked up daily from the Document Room (Room 145-N, State House, Topeka 66612, 913/296-4096) opposite the "cage" elevator on the first floor of the Kansas State House. Besides bills, the Document Room also has available the daily House and Senate journals and calendars, resolutions, and the weekly Senate and House Actions Report and Subject Index Report. In addition, committee lists for both the House and Senate are available from the Document Room. All these documents are free. A bill subscription service is also provided. It includes the daily mailing of all these documents. Cost is $175.00 (first class), $95.00 (in-state third class), and $140.00 (out-of-state third class). Also available is a partial service for $50.00 which includes daily journals and calendars, as well as the Report. For either service contact the Division of Legislative Administrative Services (Room 511-S, State House, Topeka 66612, 913/296-2391).

BILL TRACKING. There are several ways available for keeping track of bills. First, follow the course of a bill using the daily calendars and journals, along with the weekly Senate and House Actions Report and Subject Index Report mentioned above. Second, the Legislative Hotline can be used to obtain background information and to check the current status of a bill. The toll free number is 1-800-432-3924. This number, which is operated by Kansas State Library (Third Floor, State House, Topeka 66612) personnel, can also be used to leave a message for a particular legislator to return a call. Third, for an annual fee of $100 plus an approved microcomputer and a modem (a device for computers to communicate via telephone lines), anyone can telephone the Legislature's bill status information database and check directly on the status of any bill at any time. If interested in computer access, call or write Mary Cheng, Revisor of Statutes Office, State House, Topeka 66612, 913/296-5289.

OTHER INFORMATION. Another helpful document available free from the Legislative Research Department (Room 545-N, State House, Topeka 66612, 913/296-3181) is the Report on Kansas Legislative Interim Studies to the 1986 Legislature. This 1200-page document includes the reports and recommendations, including bill drafts, of all legislative committees that met to conduct studies between sessions. Excellent background publication. Also copies of the Budget in Brief and The Governor's Legislative Message are available free from the Division of the Budget (Room 152-E, State House, Topeka 66612, 913/296-2436).

LEGISLATIVE HOTLINE NUMBER: 1-800-432-3924

MEMBERS OF THE HOUSE INSURANCE COMMITTEE

Deanna - is his secretary -

Rep. Rex Hoy, Chairperson	R-Fairway	913-296-7664
Rep. Dale Sprague, V-Chairperson	R-McPherson	7682
Rep. William Bryant	R-Washington	7670
Rep. Burt DeBaun	R-Osage City	7684
Rep. Clyde Graeber	R-Leavenworth	7670
Rep. Kenneth King	R-Leon	7644
Rep. Marvin Littlejohn	R-Phillipsburg	7668
Rep. James Lowther	R-Emporia	7662
Rep. Melvin Neufeld	R-Ingalls	7676
Rep. Larry Turnquist	D-Salina	7647
Rep. Gary Blumenthal	D-Merriam	7699
Rep. Theo Cribbs	D-Wichita	7697
Rep. Diane Gjerstad	D-Wichita	7639
Rep. Jack Lacey	D-Oswego	7690
Rep. Patricia Weaver	D-Baxter Springs	7693

MEMBERS OF THE HOUSE JUDICIARY COMMITTEE

Rep. Joe Knopp, Chairperson	R-Manhattan	913-296-7688
Rep. Robert Wunsch, V-Chairperson	R-Kingman	7674
Rep. Edwin Bideau, III	R-Chanute	7672
Rep. Frank Buehler	R-Claflin	7646
Rep. Stephen Cloud	R-Lenexa	7686
Rep. Arthur Douville	R-Overland Park	7642
Rep. Santford Duncan	R-Wichita	7678
Rep. Wanda Fuller	R-Wichita	7654
Rep. Richard Harper	R-Fort Scott	7653
Rep. Michael O'Neal	R-Hutchinson	7646
Rep. Vincent Snowbarger	R-Olathe	7640
Rep. Robert Vancrum	R-Overland Park	7655
Rep. Thomas Walker	R-Newton	7652
Rep. John Solbach, III	D-Lawrence	7699
Rep. Joan Adam	D-Atchison	7699
Rep. Ruth Luzzati	D-Wichita	7693
Rep. William Roy, Jr.	D-Topeka	7639
Rep. Jack Shriver	D-Arkansas City	7694
Rep. George Teagarden	D-LaCygne	7697
Rep. Joan Wagnon	D-Topeka	7647
Rep. Donna Lee Whiteman	D-Hutchinson	7647

LEGISLATIVE HOTLINE NUMBER: 1-800-432-3924

MEMBERS OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE:

Sen. Roy Ehrlich, Chairperson	R-Hoisington	913-296-7354
Sen. Jack Walker, V-Chairperson	R-Overland Park	7382
Sen. Eugene Anderson	D-Wichita	7387
Sen. James Francisco	D-Mulvane	7367
Sen. Leroy Hayden	D-Satanta	7378
Sen. Dave Kerr	R-Hutchinson	7368
Sen. Bill Morris	R-Wichita	7385
Sen. Bill Mulich	D-Kansas City	7357
Sen. Ed. Reilly	R-Leavenworth	7372
Sen. Alicia Salisbury	R-Topeka	7374
Sen. Ben Vidricksen	R-Salina	7390

MEMBERS OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE:

Rep. Marvin Littlejohn, Chairperson	R-Phillipsburg	913-296-7668
Rep. Elaine Hassler, V-Chairman	R-Abilene	7641
Rep. Edwin Bideau	R-Chanute	7672
Rep. William Bryant	R-Washington	7670
Rep. Frank Buehler	R-Claflin	7646
Rep. Dorothy Flottman	R-Winfield	7692
Rep. Ben Foster	R-Wichita	7698
Rep. Jerry Friedeman	R-Great Bend	7641
Rep. Melvin Neufeld	R-Ingalls	7676
Rep. Mike O'Neal	R-Hutchinson	7646
Rep. Jo Ann Pottorff	R-Wichita	7681
Rep. Vernon Williams	R-Wichita	7677
Rep. Jessie Branson	D-Lawrence	7689
Rep. Gary Blumenthal	D-Merriam	7699
Rep. Theo Cribbs	D-Wichita	7697
Rep. Kenneth Green	D-El Dorado	7665
Rep. Jesse Harder	D-Buhler	7665
Rep. Judy Runnels	D-Topeka	7689
Rep. Joan Wagnon	D-Topeka	7647

March 5, 1986

Rep Hoy, Chairman and Committee Members:

I am writing in support of House Bills 3062 and 3064. I have read and studied the task-force report titled "Alzheimer's and Other Related Diseases" with great interest. You see, during the Carter administration there was a similar congressional study -- in fact, Wichita was one of 6 sites across the nation for testimony. The important similarity in these studies is that the problems and needs are the same as those documented over 10 years ago. How long should these families wait?

I am 37 years old. My mother has been in a nursing home with Huntington's Disease for 21 years now and her average monthly care costs are $1600 - 2000. My father is unable to get additional financial aide for her because he still owns his own home! The "Division of assets" recommended in the study only seems fair and just. If respite-care had been available back then, perhaps she could have stayed in a home-care envionment much longer. Why should anyone be made to be the total financial, emotional, spiritual and medical care-giver without any support. (And believe me, my father was constantly appealing through courts, attorneys, politicians, priests, friends, social workers, etc..)

Huntington's Disease has a 50% hereditary chance. So, here I am reaching an age where if I do carry the gene, I too will start to show symptoms. Am I to believe that it would be no more hopeful for me than for my mother over 20 years later? That would be a pretty sad testimony and my faith in mankind and the democratic process would take a giant step backwards.

PLEASE PLEASE -- I am appealing not only for myself and my family but for the many other HD families I have grown to know and love across our State.

Very respectfully submitted,

Mary C. Noonan

Mary C. Noonan
3455 N. Arkansas Ave.
Wichita, Kansas 67204
(316) 838-2394

C.

March 5, 1986

Mr. Rex Hoy
Kansas House of Representatives

Re: House Bill 3062
House Bill 3064

Dear Mr. Hoy:

We are writing to request your support of House Bills #3062 and #3064 which would provide some measure of relief for victims of Alzheimer's Disease and their families, who endure financial hardships as a result of this affliction.

Through our close involvement with the Kansas Chapter of the Huntington's Disease Foundation of America (former President and Patient Services Chairperson) we have seen the total ruin that a long-term illness of this kind can bring upon a family.

As taxpayers, voters and lifetime residents of this state, we strongly urge you and your colleagues to provide some

d.

assistance for those who find themselves in a position of losing everything to care for loved ones.

Thank you for your support.

Sincerely,

Mike Reichenberger
Judy Noonan-Reichenberger

March 5, 96

Mr. Ray Hoy
Kansas House of Representives

Re: House Bill 3062
House Bill 3064

Dear Mr. Hoy:

I am writing on behalf of my Mother, Doris M. Noonan;

She has been a Huntington's Disease patient for 21 years, and is in a nursing home. Her husband of 44 years raised 10 children alone. He has been finacially and emotionaly destroyed.

If Doris Noonan could write to you, she would ask that both of those bills are desparately needed, so please pass them.

Thank you,
Doris M. Noonan
Daughter Judy Noonan Reichenberger
Wichita Care Center
1319 Mary
Wichita, Ks.

e.

3/6/86

Dear Mr Hoy

I'am writing in regards to House Bill 3062 & 3064. I Believe our country has a great need for both of these bills. With all the diseases that have afflicted this country, & researchers finding more & more that affect a person for 5yrs or longer. ~~People~~ families ~~are~~ cannot afford to have them cared for. Especially long term in care homes ect. The expense is tremendous & a great emotional stress on the families. There are more people who need both these bills passed through than anyone can imagine. My husbands family has felt all the strees & emotions on trying to keep there mother in care home because she has huntingtons disease. The expense is aplox 2000.00 a month. Now you tell me unless you make more than 40.000.00 a yr you can not afor to live yourself & let alone the afflicted family member ~~or~~ unless award of the state & that's hard to do. If you have more than 1 family members afflicted who lives & who dies & 7-10 ~~dont~~ commit suicide because the cannot support those afflicted or themselve.

f.

Theresa Owen
1330 S. Lulu
Wichita, KS 67211

3-6-86

Regarding House Bill 3062 and House Bill 3064

Dear Mr. Hoy,

I am a lifetime resident of Kansas. I am twenty-seven and have consciously chosen to stay in Kansas because of its people & political climate. I believe in our people and their integrity.

There is a desparate need for long term care assistence and disability assistence. There are no options for a spouse to sustain any quality of life in case of long term illness.

Quality of life is self respect, An obstacle or crisis of great measure can far out strip a persons resources. In such a case a person can spend more than they have personally, emotionally, financial. What is left is a shell of a person who is wasted.

I plead with you to recognize the need and ~~postpone~~ take action according to your own integrity

Sincerly

Patrick J Noonan

1330 S Lulu
Wichita, Ks
67211
265 3409

January 13, 1986

Jan Bender
3315 E. Mt. Vernon
Wichita, KS 67218

Michaela Stenger
Outreach Counselor
Kansas Chapter HDFA
2721 Boulevard Plaza
Wichita, KS 67211

Dear Michaela:

In response to your request, I have prepared a few statements concerning any problems I have encountered involving health insurance.

My mother was placed at Larned State Hospital in December of 1969. She had been diagnosed as having Huntington's Disease, an incurable, chronic disorder of the central nervous system. My father was financially unable to afford to raise three teenage children and also pay for nursing home care for my mother. His medical insurance paid for her care for a limited time, after that the responsibility fell completely to my father. The social worker at Larned would call my father continuously, asking for more money.

My father died of cancer in February of 1972. I must often wonder if his death was indirectly caused from his difficulties in dealing with the problems created by my mother's illness. I was fifteen years old. The state took possession of the family home in order to pay for my mother's debts. We were allowed to remain in the home until I turned eighteen, at which time it was sold.

At this time, I am unaware of any health insurance which pays for nursing home care on a long-term basis. The only solution seems to be to purchase large amounts of life insurance which can pay off the accumulated debts after one's death. As I am at risk for Huntington's Disease, this may be my only alternative. Imagine my distress if I find that I must bankrupt my family in order to receive assistance.

J.

Another problem I may encounter involves my future inability to pick up insurance should I show symptoms or if a pre-symptomatic test should be developed. At this time I am insured under my husband's company insurance. My fear is that he will change companies eventually or be layed off, in which case we would lose my coverage. Up until a year ago, I carried my own personal health insurance, but at an annual rate of $500.00 and increasing, we could no longer afford the additional policy. Even if I should be insured, I have been told by various insurance agents that a rider would probably be attached to the policy stating that no benefits would be paid for any health problems relating to Huntington's Disease.

Because of the early age of onset of symptoms(35), many patients do not qualify for aid that elderly persons under similar circumstances are able to receive. Many families must bankrupt themselves to fit into the stringent guidelines required by public programs. There does not seem to be any way to adequately prepare, except, as I heard one expert explain, "to jump off a tall bridge".

I would like to be able to plan to live as normal a life as possible, as long as possible. I would not mind participating in an insurance program, if I could be assured that it would protect me when I needed it. At this point in time, there are no guarantees. If HD families could be assured of financial assistance in caring for HD affected individuals, they could devote more time and energy in dealing with the many other problems associated with the disease. And the affected person would not have to worry so much about creating a financial burden on the family.

I hope this may be of some assistance to you.

Thank you for asking.

Sincerely,

Jan Bender

h.

303 West 3rd
St John, Ks. 67576
Dec 6, 1985

Dear Michaela:

Thank you for the invitation to the Holiday Family gathering. We would love to come but have a conflicting engagement, one that we can't very easily change.

I do want to tell you that we had a letter from the State Insurance Commissioner. He said they could find no company that would insure someone with H.O., but he suggested some companies out of the State to try; however, we contacted Blue Cross and finally they sent John a contract with a rider which excludes treatment for nervous ailment or gastro-intestinal. (He had Crohn's disease in 1980) We're going ahead with this and sent in the $50 for the first monthly payment.

Tell the group we thank them for all their suggestions. Sorry we can't be with you.

Have a Happy Christmas.

Love, Helen & John Rauber

10 18-85

Information for Michaela Stenger, H.D. Outreach Coordinator

1. Name — John Thomas Reuber
2. Birthdate — October 8, 1940
3. Diagnosed
   a. When — February, 1983
   b. By whom — Dr Richard Sohn, Neurologist
      Barnes Hospital, St. Louis, Missouri

4. Events concerning his loss of insurance coverage:

Since 1966, John had Missouri State Teachers' Association Medical Protector Insurance with his family. Both he and his wife were teachers in the Sikeston, Missouri school system. After he was diagnosed as having H.D. and given disability retirement, his wife wrote me that she could not cope with the situation, and she urged him to come visit me in Kansas, which he did in June, 1984. She then called him out here and told him not to come home, that she wanted a divorce. The divorce was granted in April, 1985. He did not contest it.

It was not until then that we learned she had changed the insurance policy from M.S.T.A. to Blue Cross. We contacted the Jefferson City office and learned that he was not covered since no premiums had been paid since October. Finally, we wrote the Forrest T. Jones Co. in Kansas City, agent for MSTA, and in August they replied, "the underwriters of New York Life have advised that they cannot authorize issuance of this coverage because of your Huntington's Disease."

I have written Fletcher Bell, Ks. Insurance Commissioner, for his advice, but have had no reply. John does not qualify for SRS, Medicare nor Medicaid although he does have a Social Security card.

KINH Kansans for Improvement of Nursing Homes, Inc.
913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY SUBMITTED TO THE HOUSE INSURANCE COMMITTEE CONCERNING HB 3062

March 6, 1986

It was reported to Alzheimer's Disease Task Force members that diability insurance carriers frequently exclude persons with Alzheimer's Disease from benefits because they are categorized as having a mental illness.

We consider this to be a discriminatory, inequitable, and unfair practice on the part of insurance carriers who have the exclusion, making the provision in HB 3062 a desirable one, in our view.

Medical research has established that the origin and cause of Alzheimer's Disease are organic, not mental or psychological. Federal Medicaid regulations recognize this fact by including treatment for Alzheimer's Disease with the program's coverage.

We support the provision of HB 3062.

Harriet Nehring, Executive Director
Kansans for Improvement of Nursing Homes

Attachment 5
House Insurance
3-6-86

KINH Kansans for Improvement of Nursing Homes, Inc.
913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY SUBMITTED TO THE HOUSE COMMITTEE ON INSURANCE REGARDING HB 3064
March 6, 1986

Kansans for Improvement of Nursing Homes is a statewide consumer organization with nearly 900 members. Our primary concern and focus is on improvement in the quality of nursing home care in Kansas, including a related issue of protecting the capability of those in need of care to afford it. Toward that objective, we believe that the concept of shared risk in insurance coverage provides real promise for keeping many more Kansas citizens financially independent when faced with the expense of nursing home care.

We believe there is a real need for better long term health care coverage in Kansas as well as in the rest of the country. We are pleased that there exists now a much greater awareness of this need and that change is occurring that will make real long term health care coverage more generally available, and we hope at more affordable rates. In our study of the issue, we have identified the following indicators of need:
--Medicare supplement policies have failed to provide protection against long term care expense. Many older citizens have a false impression that those policies will meet all their health expenses not covered by Medicare. In truth, nearly all such policies apply only to very short term care in a skilled home. Most Kansas nursing homes are intermediate care homes and are thus disqualified from providing care under the policies. Frequently policies supplement only maximum Medicare benefits. Unless full Medicare benefits are realized, there is no supplementary coverage. The high rate of denials on Medicare claims for long term care makes this kind of coverage useless.
--There is a growing number of older people in the population, especially among the upper age group over 85. It is a fact that the more advanced one's age, the greater the likelihood for the possibility of needing long term care. For persons over 65, there is a one in five chance that they will spend some time in a nursing home before

Attachment 6
House Insurance/3-6-86

they die, and that chance increases with the continuing age trend.

--Nursing home costs to consumers have recently escalated dramatically. Recently arrived large corporate owners are exercising monopolistic rate setting policies that cause earlier depletion of life savings in order to pay for necessary care and force people who have never been poor in their lives onto the Medicaid program. Most people do not want to become dependent on government assistance, but they have no choice.

--The shifting burden of many federal government programs to the states is stretching their capability to provide for the needs of their citizens as they have in the past.

--The average length of stay in a nursing home has been estimated to be about three years. We are now observing the need for institutional care of a much longer term nature because of some diseases such as Alzheimer's Disease, which has an average period of six years to run its course, and frequently many more years. These Alzheimer's patients make up an estimated 40-60 percent of the resident population in intermediate care homes.

--Non-institutional long term care is an important component of the needed insurance program. It is less costly and the preferred option of many people. This inclusion in available coverage should help to reduce the cost of long term care insurance.

In the absence of industry initiatives to provide needed long term health care insurance, the requirements in HB 3064 setting minimum levels of optional long term benefits for all health insurance providers in Kansas seems entirely warranted and justified. It is a very serious and critical need now and cannot be delayed any longer. We believe that the public wants long term health care benefits. Therefore, we request a favorable report on HB 3064.

Harriet Nehring, Executive Director
Kansans for Improvement of Nursing Homes

estimony in support of HB 3064

My name is Wanda Blaser. I am a registered nurse and have my master's degree in nursing. I teach for the University of Kansas and currently serve as president of the Alzheimer's Disease and Related Disorder's Association (ADRDA), Topeka Chapter.

From my work as a support group leader and at the task force hearings I have heard the priority family concerns as need for some type of finanacial assistance and acceptable insurance coverage. A quote from Meiners (1985) summarizes the problem well. Long term care expenses are frequently catastrophic for elderly persons needing such care. Medicare is not designed to cover long term care, and private insurance is not generally available to fill this gap. Without the benefit of private insurance for long term care, payments for those services have come to represent the largest out-of-pocket health care liability for the aged. Thus, as a result of funding their own extended care needs, many people become candidates for Medicaid. I speak in support of HB 3064 for the following reasons:

1. Current insurance policies do not cover Alzheimer's families needs. Reimbursable phrases such as acute care and rehabilitative potential do not apply to the Alzheimer patient. The Alzheimer's family though is providing care to a progressively deteriorating patient who may be incontinent and unable to perform even the simplest tasks for himself. The term custodial care has been used to describe these problems even though they place heavy physical demands on the caregiver.

2. Progressive debilitating diseases deserve insurance reimbursement. Alzheimers disease lasts an average of 8-10 years with some patients living up to 20 years. A social support service such as adult day care may cost only $35.00 a day, but when multiplied over this time span the price becomes exorbitant for a family caregiver. Certain acute care surgeries may cost $125,000 or more, but they are covered by insurance. This same amount of money could be used to provide health and social services to an Alzheimers patient for five years or longer.

3. Coverage of community based long term care services may prevent acute care costs or premature nursing home placement. Services such as case management can provide monitoring of the Alzheimers patients ever changing problems in areas such as nutrition, hygiene, and physical health. Early intervention or referral to the appropriate services such as the home health nurse may prevent the onset of acute conditions requiring hospitalization. As families have the opportunity to afford services such as homemakers and home health aides they often find their ability to care for the patient in the home can be extended, delaying nursing home placement.

4. Coverage of long term care needs may prevent a second patient. Research supports that families do provide home based care to their frail elders including Alzheimers patients. This care is often extended to the point where the caregiver becomes exhausted, physically ill, and may then himself become a patient possibly in need of acute care insurance.

I ask yor support for HB 3064 with the hope that you will respond to the demonstrated need of our Alzheimer's families.

Meiners, M. (1985) Long Term Care Insurance, Generations: 9(4).

Attachment 7
House Insurance
3-6-86

KANSAS DEPARTMENT ON AGING
TESTIMONY ON H.B. 3064
COMMITTEE ON INSURANCE
MARCH 6, 1986

Bill Brief:

Act would amend existing insurance laws to require all health care policies sold in the state to include an option for coverage of long-term care services, both in-home and institutional.

Bill Provisions:

1) Individual or group accident and sickness insurance policies must provide for reimbursement indemnity of long-term care services.

2) Minimum services provided may be either in-home or community based.

3) Limitation on in-home services are:
   Adult day health - 8 hours per week
   Home health aide - 4 hours per week
   Homemaker - 4 hours per week
   Respite care - 50 hours per year
   Case management - 24 hours total

4) Limitation on community based services is:
   Intermediate care facility and adult family home services - two years in any combination.

5) Policy must provide for not less than 75% of cost of services provided.

6) Insured is eligible for only in-home services or community-based services at one time.

7) Policy shall not contain prior hospitalization clause.

8) Any pre-existing condition clause shall not require a waiting period of more than six months.

9) Provisions are applicable to health maintenance organizations.

Background:

This legislation is one of the recommendations of the Kansas Alzheimer's and Related Diseases Task Force. The Task Force was created by SCR #1618 in April 1985 to study Alzheimer's and related diseases and recommend legislative action.

Attachment 8
House Insurance
3-6-86

Testimony:

Nursing home care is the largest catastrophic expense for individuals age 65 and over. Today the average annual nursing home cost is approximately $20,500 per patient. In 1984, 50.1 percent of the cost of nursing home care was paid directly out-of-pocket by the elderly and their families. Medicaid covered 41.5 percent, Medicare 2.2 percent and other funding sources contributed 5.1 percent. The remainder, only 1.1 percent, was paid by private insurance.

According to a recently released study by the U.S. House Select Committee on Aging, two-thirds of individual and one-third of couples aged 66 and older will spend themselves into poverty within 13 weeks if stricken by chronic illness that requires long-term care. Although only 5 percent of the elderly reside in nursing homes at any one point in time, it has been estimated that 15 to 20 percent of the elderly will have had some contact with a nursing home in their lifetime. The point-in-time use of nursing homes increases from 1.4 percent of persons age 65 to 74, to 20 percent for persons age 85 and older.

Three-fourths of the elderly will never have a nursing home experience and one-third of those who do will be institutionalized for less than one year. However, these people are likely to be in need of some type of in-home care service.

Home care is also expensive. In a recent study of Alzheimer's victims in Massachusetts, survey data show that one of six married couples (16 percent) aged 66 and older risk impoverishment after 13 weeks of home care, and nearly half (46 percent) face impoverishment after one year. The analysis of financial risk among the elderly in Massachusetts is illustrative of what is happening to the elderly across the country, including Older Kansans. As more Older Kansans find it necessary to become impoverished due to their long term care needs, costs to the state and the nation providing this care are increasing rapidly.

The clear majority of our elderly are virtually unprotected from the devastating costs of chronic illness. Many older consumers underestimate the degree of coverage provided by Medicare. Actually, Medicare assists about only one percent of the people admitted to skilled nursing facilities and seldom covers more than a few days stay. Likewise, private health insurance policies purchased by the elderly prove to be duplicative and expensive but virtually useless when the total costs of long term nursing care are considered.

It has been estimated that approximately two-thirds of all nursing home patients who originally try to pay for their care within a year's time deplete their resources and are forced to turn to Medicaid. Medicaid, therefore, is paying the nursing home costs of not only the poor, but also of the middle class elderly who become impoverished because of their chronic care needs.

Long-term care insurance can curtail the rate of conversion from private pay patients to Medicaid. Recent data on the income and resources of older Americans suggest that long-term care insurance is well within the means of most senior citizens. Many of the individuals currently spending down to become Medicaid eligible could have afforded private insurance protection for long-term care. When the cost of full time nursing home care is at least $20,000 a year, many people can see the logic of spending as much as $1,200 a year for long-term care insurance.

Long-term care insurance is not new. Several smaller insurance companies have been marketing these policies for at least eight years and approximately 100,000 persons currently hold them. However, many of the policies exclude certain major illnesses--such as Alzheimer's disease--from coverage. Long-term coverage for home care is even more rare than long-term nursing home insurance. Many elderly individuals could avoid nursing home care by receiving instead less expensive noninstitutional services.

H.B. 3064 would cover services that are not covered under Medicare (adult family home and intermediate care facility services). It would also serve to remove some of the bias toward institutionalization that is now inherent in Medicare, Medicaid and most private insurance plans. Elderly people prefer to remain in their own homes if only they can receive the services they require. And in-home care, as we know, is less expensive than institutional care.

There are several important benefits that the passage of H.B. 3064 would result in. Long-term care insurance will preserve the dignity of elderly persons by giving them the opportunity to prudently plan for their potential long-term health care needs. Long-term care insurance can help reduce the reliance upon public programs as the source of payment for such services; the government can not be the ultimate financer of long-term care needs. Long-term care insurance can prevent families from impoverishing themselves. Long-term care insurance can benefit providers by expanding their pool of private payers and reducing their dependence on public programs. Finally, the development of the private insurance market offers a new growth potential for the insurance industry.

America's elderly - Kansas elderly - are at risk, physically and financially. Chronic illness does not discriminate by income level. For many people, the burden of chronic illness or caring for a loved one with a disabling disease such as Alzheimer's is made that much more difficult in the face of financial destitution. The daily rates for home care or nursing home care are unpredictable catastrophic expenses that far exceed their life savings.

We can reduce the risk. The Kansas Department on Aging strongly supports, and requests this committee's favorable passage of, H.B. 3064.

JVR:SW:mj
3/6/86

Health Insurance Association of America
Statement Concerning
Long Term Care

Long term care can mean more than just a protracted stay in a nursing home. It is a complex area of need which includes a variety of medical and nonmedical services. The cost of those services is an emerging concern of the elderly in the wake of heightened sensitivity to their potential risk of requiring some type of long term care services.

It has become increasingly clear in recent years that neither federal nor state government will be able to provide the long term care services needed by our nation's growing elderly population. Medicare and Medicaid, the two programs that would normally assist the elderly, are already being restricted as part of federal deficit reduction efforts, and will not be significantly expanded. Consequently it has fallen to the private sector to undertake the difficult task of underwriting expanded and different forms of long term care coverage.

Nursing home expenses are the largest single out of pocket health care expense faced by the elderly. The purchase of private insurance is one way to relieve the growing pressure on family resources caused by the elderly's long term care needs. Currently, insurance companies offer policies, on an indemnity basis, which provide nursing home or home health care benefits beyond those covered by Medicare. Most long term care policies pay a fixed amount per day for covered stays in nursing homes. These products are designed to help provide protection from catastrophic long term care expenses and are primarily sold to individuals.

Long term care policies provide different lengths of coverages and different types of nursing home benefits. Some policies provide coverage only for short stays in nursing homes. Other policies provide coverage for longer stays of up to three or four years. These insurance policies usually provide different benefit levels in terms of dollars or days of coverage, depending on whether the insured is receiving skilled, intermediate, custodial or home care. Benefits are designed this way for several reasons. It costs more to receive a higher level of care than to receive a less intensive level of care, and the benefit levels reflect this pricing structure of providers. By providing benefit levels at a fixed amount for each day of covered service, patients and their families are given a reason to find efficient providers who can supply needed care within the benefit level. Limits are thus placed on an insurer's liability under any one policy, and the risk of providing insurance is somewhat reduced.

Many earlier forms of long term care insurance policies emphasized nursing home coverage over home care for a variety of reasons. Insurance must clearly define the risk covered and should provide coverage designed to avoid anti-selection. Entry into a nursing home is an event which is more easily identifiable and is less within the subjective control of the insured than in the case of home health care. Due to the difficulty of distinguishing among levels of care, some companies limited coverage to skilled and intermediate nursing care. Other companies required custodial or unskilled care to be preceded by a period of skilled nursing care in order to assure that the care received was due to medical necessity. Innovations in the levels of care covered by long term care policies are now underway, with the offering of benefits for less than skilled nursing care. Some carriers have introduced policies which will pay a daily benefit for each day a person receives

custodial care following a specified time period during which the beneficiary receives continuous skilled nursing care. Policies combining home health care and nursing home benefits with long term care coverages are becoming more prevalent in response to increased consumer interests according to recent surveys.

In addition to variations among benefits, the cost of long term care insurance varies among policy type and company. Designing and underwriting these products is not a simple matter. It is difficult for insurance companies to develop underwriting standards, and to design and price nursing home and home health care benefits. One of the major problems is projecting what the utilization will be. Generally speaking, the existence of insurance coverage for a particular service leads to an increase in its level of utilization. There is not enough experience at this time to predict the effect of this phenomenon on nursing home coverage. There is also the further consideration of adverse selection; the situation where persons with a high likelihood of benefit utilization because of family history or known medical conditions buy policies to cover these expected losses. It is also difficult to determine when the insurable event occurs when dealing with home health care services. Insurers attempt to address these problems in a number of ways. Conditioning home health care benefits on having been confined in a hospital or a nursing home, or on needing the benefits within a certain number of days after discharge tends to ensure the necessity of utilizing the care. This also helps relieve the bias toward long-term institutionalization by providing the beneficiary with benefits when he or she is discharged to home care. Benefits may provide a certain dollar level for each day of home care, or may be designed to trade off a day of inpatient nursing home care for each day of home health care received. A few policies emphasize home health benefits over nursing home benefits with the goal of covering personal care services in order to keep the beneficiary from being institutionalized. This approach though needs a strong case management program and a relatively concentrated group of policyholders to be feasible. It is also virtually impossible to predict what the cost of nursing home care and home health care services will be several years in the future when benefits might be used. In most cases claims experience under a particular policy takes several years to develop, and in designing benefit levels companies are required to look some distance into the future. By focusing on indemnity type benefits, carriers are able to make projections based on a fixed benefit level.

Long term care policies have different lengths of coverage, elimination periods and benefit amounts, and in some cases different benefit levels may be offered in the same policy. There is a large variation among premiums, but typically rates range from $15 to $90 a month, depending on benefit levels selected and the age of the purchaser when the policy is issued.

The National Association of Insurance Commissioners (NAIC), and the Health Insurance Association of America (HIAA) have both recognized the need to address the area of long term care insurance. Both organizations have appointed high level task forces to study this topic. They are carefully examining such issues as: (1) the removal of existing regulatory barriers to the development of long term care products, (2) alternative and innovative funding mechanisms, (3) actuarial data necessary to determine appropriate pricing, (4) incentives for the purchase and sale of these products, (5) development of educational materials for the public and industry and (6) appropriate regulation of LTC insurance. Both NAIC and HIAA are currently developing recommendations in these six areas, which are expected by the Fall of 1986.

To address the variety of demands in the marketplace, future long term care insurance products may need to combine aspects of various forms of coverage such as disability, health, and annuities into new and different types of insurance.

Long term care insurance is in an embyronic stage of development and as yet, it is not known which policy designs might work best. Established carriers are entering this market but products are in an evolutionary stage. The challenge for insurers is to establish benefit levels and premium charges in products which minimize insurance induced demand for services and adverse selection, which avoid stimulating increased provider charges, and which provide meaningful benefits to consumers.

Respectfully Submitted,

Stephen W. Robertson

Stephen W. Robertson
Counsel

SWR/cp