Approved Feb. 5, 1987
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by VICE CHAIRMAN, Frank Buehler at
Chairperson

1:30 /~~/~~/p.m. on February 4, 19 87 in room 423-S of the Capitol.

All members were present except:

Chairman Marvin Littlejohn, Representative Blumenthal, Representative O'Neal, all excused.

Committee staff present:

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

Conferees appearing before the committee:

Mrs. Rita Wolf, Department of Health and Environment
John Schneider, department of Social Rehabilitation Services
Dr. Ron Harper, Department on Aging
Ralph W. Wright, STate Legislative Committee-AARP
Barbara J. Gibson, Statewide Health Coordinating Council
Kay Kent, Douglas County Health Department
Sister Ann Marie, President of St. Francis Hospital
Lynn Barclay, Children's Coalition
Gail Hamilton, National Organization of Women

Vice Chairman Buehler called meeting to order when quorum was present. He invited Staff to brief committee on HB 2014.

Ms. Correll and Mr. Furse both gave a comprehensive briefing on HB 2014.

Vice-Chairman welcomed Lt. Governor Jack Walker to our meeting this date.

Hearings began on HB 2014.

Mrs. Wolf, Department of Health and Environment gave printed testimony to members, (see Attachment No.1) for details. In way of background information, she stated that 581,000 individuals in Kansas are unable to pay for their health care. The medically indigent are not the very poor who are eligible for Medicaid or Medikan. Most of the medically indigent are employed full or part-time in jobs where no health insurance is provided. Others are unemployed, therefore uninsured, or have chronic health problems that prevent them from acquiring health insurance. Other groups of medically indigent are low income women and children, displaced farmers, black Kansans, and migrant workers. Consequences of not addressing this issue will be severe in terms of human suffering and in terms of dollars spent in hospital emergency rooms. The long-term savings will be recognized through the availability of preventive services, but the provision of these services will require a financial commitment by the State.

The commission that would be established by this bill will have the potential to research and design efficient and cost-effective methods of addressing these problems. Their Department urges for favorable support of HB 2014.

John Schneider, Department of Social Rehabilitation Services, (SRS) gave printed testimony, (see Attachment NO.2), for details. He spoke in support of HB 2014 and the Commission that would be organized to study and review the issues of access to services for the medically indigent and homeless over the next two years. He defined "medically indigent" to include individuals who do not qualify for State medical Assistance (MA). He defined the financial and nonfinancial reasons why individuals do or do not qualify for medical assistance. He stated the growing homeless population has caused widespread concern and attention. There are no firm statistics to illustrate the full extent of this problem because of its complexity and the kinds of people that are homeless. Some programs are currently helping, but the problem is so widespread more help is desperately needed. Their department urges for support of HB 2014 as a means toward resolving the problems of the medically indigent and homeless in Kansas. He answered questions from members.

Hearings continue on HB 2014:

Dr. Ron Harper, Department on Aging spoke in support of HB 2014, and gave hand-out to members, (see Attachment NO.3), for details. This act he said would create a Commission on access to services for the medically indigent and homeless. This Commission would consist of 9 members, could study and review access to services for the indigent and homeless, could submit an annual report of findings and recommendations to the Governor and Legislature by December 15th of each year, would be staffed by Revisor of Statutes, Legislative Research, Administrative Services, Division of Post Audit personnel, and the powers of commission would expire December 31, 1989. He noted that 43 of 49 states responding to a survey placed indigent care highest on their list of priorities. Since 1979 there has been an increase of 20% in the number of Americans under age 65 who lack health insurance. The common perception that the elderly are taken care of by Medicare and Medicaid is not founded.

Older persons are uninsured for many reasons, i.e., unemployed, retired early and not eligible for health insurance from employer anylonger, working at part-time jobs that do not offer health coverage as a employee benefit; in service industries, or agriculture, where insurance coverage is not offered, widowed or divorced and no longer covered under Spouse's insurance, or may have high-risk health condition not covered by insurance, or they may be poor. He urged for support of HB 2014. He anaswered questions from members.

Dr. Harper stated he had a follow-up to comments made earlier on Hearing HB 2018, and some statements corrected are shown in hand-out given this date. (This Attachment will be shown as (Attachment No.3-A).

Vice-Chair called attention to Attachment (NO.4) a hand-out from AARP in regard to the medically indigent. This hand-out sent to Chairman from James V. Behan, Chairman AARP.

Mr. Ralph W. Wright, State Legislative Committee representative of AARP gave printed testimony, (see Attachment NO.5), for details. He stated they intend to to represent this large number of the Kansas population. He detailed his printed testimony and in closing stated their recommendations, i.e., immediate re-examination of the use of Medicaid in Kansas; set priorities as the most needy to be served first; they feel the current research shows ample guidelines for prompt action; and the state budget should reflect efforts to relieve the suffering.

At this point Vice-Chair pointed out that the fiscal note on HB 2014 has been given to each member and staff this date. This is shown as (Attachment NO. 6).

Barbara J. Gibson, Statewide Health Coordinating Council gave hand-out to members, (see Attachment NO.7), for details. She noted SHICC has two recommendations, i.e., The Commission to study the multi-facet issues that make this a comprehensive problem. The solutions to these problems will also need to be multi-faceted in order to help the varied groups in need. She hopes that as this study is being done, implementation or promotion to act during the study as it unfolds. As the study by the Commission resolves solutions they can be implemented then and not wait until after the 2 year study is completed. Further they recommend the creation of a Commission on Access to Services of the Medically Indigent and Homeless. The SHICC adopted a report entitled, "The Medical Indigency Crisis in Kansas" and truly there is a crisis. She spoke to the problems of the farm crisis and primary care doctors are saying there is increase in persons going for medical care later than they should, there are more stress related problems, and more persons less able to pay for their medical care. This too is a crisis situation and must be delt with.

At this time there was discussion in regard to the fiscal note, and Ms. Correll said she was unclear about the fiscal note, and felt exact costs could be computed for HB 2014.

Questions were answered, i.e., perhaps it would be a better plan to have this Commission operate under the premise that as solutions are determined, they could be implemented at that time and have it function as a continuing process.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 a.m./p.m. on February 4, 19 87

Hearings continue on HB 2014:

Kay Kent, Douglas County Health Department gave hand-out, (see Attachment No. 8), for details. She explained that Douglas County has citizens who lack private or third-party coverage and the personal resources to pay for their health care, and their Health Department does not provide acute illness care. She stated they are in full support of HB 2014 since it is desperately needed to address the problems of the medically indigent and homeless. She noted the attachment is a comprehensive report that was prepared for Interim Committee that she felt would be beneficial information for committee members. She answered questions i.e., what are the cost figures for delayed medical care, and yes, perhaps figures could be obtained from some studies that have been completed; also she sees an increased demand for local Health Departments after current cuts by SRS, and the need will grow for preventive care and acute illness care.

Mr. John Holmgren, Executive Director of Catholic Health Association of Kansas introduced Sister Ann Marita, President of St. Francis Hospital, Topeka as conferee for their interests in HB 2014.

Sister Ann Marita gave hand-out to members, (see Attachment NO.9), for details. She stressed their support for HB 2014. There is great need to help the thousands of Kansas people who are currently denied access to health care who are the unemployed, the uninsured, those no longer eligible for Medicaid or Medi-Kan. We do not wish to deny them admission because of lack of funds or insurance, but we are concerned we may not be able to provide this care adequately in the future unless there is some support help from local and state government. Hospitals are probably the only entity where people can receive service without paying in advance. You cannot receive goods/service from a grocery,
furniture, clothing stores without paying before you leave. She answered questions, i.e., yes, I am aware there are hospitals that are turning away patients because they lack the funds to pay for needed medical care, and yes, it is a growing problem. You cannot spend more money than you take in, and you have to run the hospital as a business. In Topeka there are no Public Hospitals for acute care patients.

Lynn Barclay, Children's Coalition gave hand-out to members, (see Attachment NO.10), for details. Their group feels there are various responsibilities for this Commission to study. More information on scope/nature of medically indigent and homeless; they could help assess and coordinate the delivery system of health care/ specific health care needs of children and pregnant women. She outlined a report they had prepared about Presumptive Eligibility and Extend Medicaid Coverage. She stressed a need for better cooperation between the SRS and Local Health Departments and Physicians. She said that there would be $.54 available from Federal funds for every $.48 of each dollar of Kansas funds spent. She answered questions.

Gail Hamilton, Kansas National Organization for women gave hand-out to members, (see Attachment NO. 11), for details. She spoke in support of HB 2014, saying lets move past public debate and the stirring hearts and improve these situations that have been identified. In the interest of time, she said she would not read through her printed testimony but she was hopeful that members would study it, and act favorably for HB 2014 passage.

May it be recorded that (Attachment NO. 12 is from Kansas Coaltion on Aging.)

Vice-Chair announced that the hearing on HB 2014 would be continued tomorrow for one additional conferee that could not be present this date. He remarked that Chairman Littlejohn continues to improve and thanks members and staff for the beautiful flowers he received from you all today.

Meeting adjourned 2:58 p.m.

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 2-4-87

NAME	ORGANIZATION	ADDRESS
Edith McBride	OBSERVER	Topeka
Jenni McBride	observer	Topeka
Gail Hamilton	KS NOW	Lawrence
Barbara Gibson	Statewide Health Coordinating Council	Halstead
JOHN H. HOLMGREN	CATHOLIC Health Assn.	1700 SW 7th Topeka Ks 66606
Mark Intermill	KCOA	1195 Buchanan Topeka.
Lita Wolf	KDHE	Topeka.
Natalie H. Coe	Ks Legal Services	712 Ks Ave, Topeka
Michele M. Onthout	Washburn University Nursing School	Topeka
Kay Kent	Lawrence-Douglas Co Health Dept	Lawrence
Lynn Barclay	Children's Coalition	Topeka
Theresa Shively	KANSAS NARAL	Topeka
Keith Albeda	Washburn Student Nurse	Topeka, Ks
Ralph Wright	AARP	Pittsburg
Bob Burkholder	AARP	Buhler
Gerald Green	AARP	Topeka 141 Wrisht Rd
Keith Wilkes	AAUP	Topeka
Ralph Brown	Silver Haired Legislature KCOA	Lawrence
John Grace	KAHCA	Topeka
KEITH L LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
[illegible]	KS [illegible]	Topeka
John Peterson	Kaiser Permanente	Topeka
Ronald L Happy	Atty Sec, KDOA	Topeka
John Myers	Kaiser Permanente	Topeka

#1.

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON H.B. 2014

PRESENTED TO HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE ON FEBRUARY 4, 1986

This is the official position taken by the Kansas Department of Health and Environment on H.B. 2014.

BACKGROUND INFORMATION:

In July 1986, the Statewide Health Coqrdinating Council (SHCC) completed a study, entitled "The Medical Indigency Crisis in Kansas," which estimates that approximately 581,000 individuals in Kansas are unable to pay for health care. The medically indigent are not the very poor who are eligible for Medicaid or Medikan. Most of the medically indigent are employed, in full or part-time jobs that offer no health insurance coverage. Others are unemployed and therefore uninsured, or have chronic health conditions that prevent them from acquiring health insurance. SHCC and the Department of Health and Environment (KDHE) identified the homeless as one group at particularly high risk of being medically indigent. Other groups include low income women and children, displaced farmers, black Kansans, and migrant workers.

The SHCC study, as well as the indigency studies by the Kansas Hospital Association and the Special Interim Committee on Public Health and Welfare all concluded that the growing magnitude of medical indigency in Kansas calls for a well documented, well researched response by the State of Kansas. The consequences of not addressing this issue will be severe, not only in terms of human suffering, but in terms of dollars spent in hospital emergency rooms, for example, for services which could be more efficiently provided in other settings, or for neonatal intensive care to treat conditions which could be prevented with adequate primary care. In the long-term, a savings will be recognized through the availability of well-organized preventive services. But the provision of these and other services necessary to care for the indigent and homeless will obviously require a financial commitment.

STRENGTHS:

The greatest benefit of the Commission that would be established by this bill, especially during a time of fiscal constraint, is its potential to research and design the most efficient, cost-effective method of addressing the medical indigency crisis in Kansas. Kansas has the advantage of being able to learn from the successes and failures of other states that have already implemented medical indigency programs, and to utilize those approaches that are the best for all Kansans.

DEPARTMENT'S POSITION:

In conclusion, the Kansas Department of Health and Environment supports the provisions of House Bill 2014.

Presented for: Jack D. Walker, M.D., Secretary
Kansas Department of Health and Environment

HP/X13

P&W
attm. #1
2-4-87

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Testimony in Support of H.B. 2014

I am appearing today in support of the proposed legislation contained within House Bill No. 2014.

The bill establishes a commission to study and review the issue of access to services for the medically indigent and the homeless. The commission is to report its findings and recommendations over the next two years for helping resolve that issue.

The Department strongly endorses this initiative as a means to begin addressing the problems of the medically indigent and homeless in this State. We believe there is a problem of growing magnitude in meeting the needs of these two groups and have reported on the extent of the problem over this past summer and fall to the Special Committee on Public Health and Welfare.

To briefly highlight our findings concerning the medically indigent, we have defined the term "medically indigent" to include those individuals who do not qualify for the State's medical assistance (MA) programs because of either financial or nonfinancial reasons and individuals who qualify for medical assistance but have medical needs which are not fully covered based on the scope of services offered in the MA programs as well as co-payment requirements. We have noted that the Department provides medical coverage to most of the groups which can be covered in accordance with federal Medicaid law. This includes families with dependent children and persons who are aged, blind, or disabled. For those who do not qualify under the Medicaid categories (primarily, single adults and childless couples), the State has provided MediKan coverage. However, only individuals who are eligible for a cash benefit under the General Assistance Unrestricted (GAU) or General Assistance Reintegration (GAR) programs can receive this coverage. If the person has too much income or resources, he or she will be ineligible for cash and, therefore, medical benefits.

We have also noted a number of significant changes on both the federal and state level which have eliminated access to medical services from either an eligibility or service-related perspective. These included:

1. Elimination of the State funded GA medically needy program in July 1981. This program provided medical coverage based on the spenddown concept utilized in the federal Medicaid programs to persons who did not qualify for a GA cash benefit because of excess income. At the time of the program's termination over 2,000 persons were involved in the program.

2. Implementation of restrictive changes in the ADC program resulting from the federal Omnibus Budget Reconciliation Act (OBRA) of 1981. These changes eliminated cash and medical eligibility for over 10,000 recipients.

3. Creation of the GAU and TGA cash programs in April 1983. This resulted in a loss of eligibility for approximately 2,000 persons due to the lower TGA standards.

pH & W Att #2 2-4-87

4. Cutback in covered medical services for the adult population in all programs over the past several years including elimination of elective surgery, limits in drug coverage, and limits in vision services.

In addition to the above changes, the Department has recently had to make further cuts due to the State's budget crisis including total elimination of medical assistance for TGA recipients, limiting the TGA program to 1 month of cash assistance in a fiscal year, further reducing MediKan coverage for adults in the GAU and GAR programs to allow for only $225 per person of inpatient hospital services in a fiscal year and 8 physician office visits in a calendar year, and elimination of dental coverage for adults in all programs.

All of these changes have exacerbated the growing problem of persons who are unable to afford basic as well as catastrophic medical care.

The growing homeless population has also generated widespread concern and attention. Because of the diversity between definitions of homelessness, there are no firm statistics to illustrate the extent of the problem. Although single males are traditionally thought of when the word homeless is mentioned, women and children are being found more frequently in emergency shelters and soup lines. It is also anticipated that elimination of monthly TGA benefits (which averaged $100) will create an increase in the Kansas homeless population.

The Department of Housing and Urban Development has provided funds allowing SRS to administer a limited housing assistance program for homeless in Greater Kansas City. The pilot project is the only Section 8 program in the nation specifically designed for homeless. Under the program eligible recipients receive monthly housing assistance which fluctuates according to changes in the household income. Since the experimental program began one year ago, HUD has increased the allocation three times, allowing for a total of 84 homeless households to be housed and to receive ongoing monthly rental assistance. According to HUD, the homeless need in Kansas City alone far exceeds their ability to fund this type of assistance.

Other SRS assistance programs are available to homeless according to the same eligibility requirements as applied to persons with homes. The Department has recently established special procedures to assure that homelessness does not prevent access to assistance.

In summary, the Department supports H.B. 2014 as a means toward resolving the problems of the medically indigent and homeless in Kansas.

Robert C. Harder
Secretary
Social and Rehabilitation Services
913-296-3271

February 4, 1987

TESTIMONY ON HB 2014
TO
HOUSE PUBLIC HEALTH AND WELFARE
BY
KANSAS DEPARTMENT ON AGING
FEBRUARY 4, 1987

Bill Summary:

Act would create a commission on access to services for the medically indigent and the homeless.

Bill Brief:

1) Commission would consist of nine members -- three from the general public and six legislators.

2) Commission would study and review access to services for the medically indigent and the homeless.

3) Commission would submit an annual report of findings and recommendations to the Governor and Legislature by December 15 of each year.

4) Commission would be staffed by Revisor of Statutes, Legislative Research, Legislative Administrative Services and Legislative Division of Post Audit personnel as required.

5) Commission's powers and duties would expire December 31, 1989.

Bill Testimony:

In August 1986, the Kansas Department on Aging testified before the Special Committee on Public Health and Welfare during the hearings held on Proposal No. 24 -- Access to Health Care for the Medically Indigent. Individuals representing 25 other agencies/ organizations also testified on the Proposal. There was unanimous agreement that medical indigency was a problem the State needed to address.

Kansas is not alone in addressing this issue. In a survey conducted in September 1986, program officials, legislators and their staffs in 43 of the 49 states responding placed indigent care highest on their list of priorities. As you are aware, this issue is also receiving national attention. Last September, the Department submitted testimony to the U.S. House Select Committee on Aging for the hearing "The Catastrophe of Uninsured and Underinsured Americans."

Since 1979, there has been a 20 percent increase in the number of Americans under age 65 who lack health insurance. In 1983, there were 3 million people age 55 to 64 without health insurance. Persons aged 55 to 64 are at the greatest risk of any age group of having inadequate coverage. This subgroup is 2 to 4 times more likely to have a chronic illness and they are 4 times as likely to be hospitalized.

PHWelf
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2-4-87

In 1983, nearly 400,000 Americans over the age of 65 were without insurance of any kind. The common perception that the elderly are taken care of by Medicare and Medicaid is not founded.

Older persons are uninsured for a variety of reasons -- they may be unemployed (and once unemployed they remain out of work longer than younger workers, increasing the risk of no health coverage); they may have retired early and are not eligible for health insurance; they may be working but do not receive insurance as a benefit of their employment (either because their jobs are low paying, part-time, with small firms, or in service industries or agriculture, so insurance is not offered); they may be widowed or divorced and no longer covered under their spouse's insurance; they may have one of the high-risk conditions that insurance companies do not cover; or they may be poor.

To personalize the issue of medical indigence, I cite examples from the files of the State Long Term Care Ombudsman.

Case No. 51 & 52 A woman who was a resident in a nursing home received medications which were not covered by Medicaid. As she was very ill at the time, she was not aware of this. Having returned home, she must make payments to the pharmacy from an income that is very limited. There is concern that her emotional state combined with her physical condition may cause her to be re-admitted.

Case No. 644 A resident has no spend-down because he has no Social Security or other pension benefits. He is totally dependent on Medicaid. He requires special medications which are not covered by Medicaid's pharmacy program. It is not known at this time how his needs will be met. The nursing home staff is required to administer the medications ordered by his physician, yet there is no way to pay for them.

Recommended Action:

The Kansas Department on Aging supports HB 2014 and encourages this Committee's favorable passage of it. The State must examine the issues surrounding the medically indigent and the homeless. The Department stands ready to provide the Commission on Access to Services with any information necessary to address its tasks.

SW:mj
2/2/87

2-4-87

TESTIMONY ON HOUSE BILL NO. 2018
BY THE KANSAS DEPARTMENT ON AGING
RONALD L. HARPER, Ph.D., ACTING SECRETARY OF AGING
FEBRUARY 2, 1987

House Bill No. 2018 transfers certain powers to the Secretary of Health and Environment concerning adult family homes.

The Kansas Department on Aging does not object to the transfer of certain powers related to adult family homes from the Secretary of Social and Rehabilitation Services to the Secretary of Health and Environment as outlined in H.B. 2018, however, it does wish to express its continuing concern regarding lack of authority for the State's Long-Term Care Ombudsman to investigate any complaints by residents of such homes.

The Secretary of the Department of Social and Rehabilitation Services has indicated that the concept of the adult family homes was modeled on the idea of family foster homes for children, and thus a non-institutional solution for adults who need a semi-structured living environment. The adult family home usually involves one to two persons in the home and should not have an institutional flavor. The Kansas Department on Aging supports this approach and further believes that posting of notices and various reporting mechanisms should be kept to the minimum necessary. With the implementation of the proposed H.B. 2018, the Department of Health and Environment will have full authority to assess compliance with requirements.

As a caution, however, I would note that such authority does not allow all complaints that residents may have to be addressed by an independent agent, such as the Long-Term Care Ombudsman. In the case of Adult Care Homes, the Long-Term Care Ombudsman has played an effective role in resolving complaints. Further federal statutes (Older Americans Act as amended 1984 and P.L. 94-566) and federal regulations (Vol. 45, No. 166, and Vol. 45, No. 63) and a memorandum from former HHS Secretary Richard Schweiker, indicate that, to comply with KDOA's federal mandate, the Long-Term Care Ombudsman should have access to relevant records of these facilities, the facility and the residents.

HHS has mandated the Long-Term Care Ombudsman to expand their programs to include board and care homes. Throughout the federal regulations concerning Long-Term Care Ombudsmen, there is the phrase, "other similar adult care homes." There is also the mandate to establish standards, "for any category of institutions, foster homes, or group living arrangements in which... a significant number of recipients of supplemental security income benefits is residing or is likely to reside." In addition, by federal statute there is a requirement "to develop comprehensive, coordinated systems of community long-term care... including noninstitutional and institutional services where appropriate."

P&HCU
attm. #3-A
2-4-87

The population of adult family homes is likely to grow in the near future. It is a reimburseable service under the State's Alternatives program and its Medicaid Home and Community based waiver. KDOA believes that wherever older people are vulnerable and dependent, in a non-family household, they should be able to call on the services of the Long-Term Care Ombudsman.

In spite of the foregoing (that would suggest that the Long-Term Care Ombudsman have authority regarding adult family homes), KDOA is willing to delay proposing extension of such authority as this non-institutional approach continues to function until such time that cases of abuse, exploitation or other relevant problems appear to exist. At such time, KDOA will propose an amendment to 75-5916(c) as follows:

> (c) "Facility" means an adult care home as such term is defined in K.S.A. 1980 Supp. 39-923 and adult family home as defined in K.S.A. 39-1501.

Such an amendment would extend the authority of the Long Term Care Ombudsman to residents of the adult care home.

Additionally, if the language of H.B. 2018 is combined with that of H.B. 2017, the Department will ask for an appropriate extension of the Long-Term Care Ombudsman's authority.

RLH:mj
1/28/87

39-1501. Adult family homes; definitions. As used in this act:

(a) "Adult family home" means a private residence in which care is provided for not less than 24 hours in any week for one or two adult clients who (1) are not related within the third degree of relationship to the owner or provider by blood or marriage, (2) by reason of aging, illness, disease or physical or mental infirmity are unable to live independently but are essentially capable of managing their own care and affairs. The home does not furnish skilled nursing care, supervised nursing care or simple nursing care. Adult family home does not mean adult care home.

(b) "Skilled nursing care," "supervised nursing care" and "simple nursing care" have the meanings respectively ascribed thereto in K.S.A. 39-923, and amendments thereof.

(c) "Physician" means any person licensed by the state board of healing arts to practice medicine and surgery.

(d) "Secretary" means the secretary of social and rehabilitation services.

History: L. 1983, ch. 142, § 1; April 21.

39-1502. Same; registration; forms. Any person maintaining an adult family home shall apply for registration of such home with the secretary on forms furnished by the secretary.

History: L. 1983, ch. 142, § 2; April 21.

39-1503. Same; registration; application for renewal; duties of secretary. (a) Upon receipt of an application for registration of a private residence as an adult family home and upon certification by the applicant that no person residing therein has an infectious or communicable disease or health condition, the secretary shall determine the suitability of the residence for registration as an adult family home. If the secretary determines that the residence for which registration is sought, and the applicant therefor, can satisfactorily meet the requirements provided in K.S.A. 39-1504, the secretary shall register the residence as an adult family home annually from the date of such registration.

(b) Application for renewal of the registration shall be made to the secretary no later than 30 days prior to the annual expiration of that registration. The secretary, within 15 days of the receipt of such application, shall cause to be made an on-site investigation of the residence. If the secretary determines that the requirements of subsection (a) of this section are met, the secretary shall again register the residence as an adult family home.

History: L. 1983, ch. 142, § 3; April 21.

39-1504. Same; requirements for registration. The secretary shall administer the adult family home registration program in accordance with the following requirements:

(a) (1) The home shall meet health standards and safety regulations of the community and the provisions of chapter 20 of the national fire protection association, life safety code, pamphlet no. 101, 1981 edition.

(2) The home shall have a written plan to get persons out of the home rapidly in case of fire, tornado or other emergency.

(3) No more than two clients shall be in residence at any one time.

(4) The home shall have adequate living and sleeping space for clients.

(5) Each room shall have an operable outside window.

(6) Electric fans shall be made available to reduce the temperature if there is no air conditioning. Rooms shall be heated, lighted, ventilated and available.

(7) Sleeping rooms shall have space for personal items.

(8) Each client shall have a bed which is clean and in good condition.

(9) Lavatory and toilet facilities shall be accessible, available and in working order.

(10) The kitchen shall be clean with appliances in good working order.

(b) (1) A healthy and safe environment shall be maintained for clients.

(2) There shall be a telephone in the home.

(3) The provider may assist a client with the taking of medications when the medi-

cation is in a labeled bottle which clearly shows a physician's orders and when the client requires assistance because of tremor, visual impairment, or similar reasons due to health conditions. The provider may assist or perform for the client such physical activities which do not require daily supervision such as assistance with eating, bathing and dressing, help with brace or walker and transferring from wheelchairs.

(4) There shall be no use of corporal punishment, restraints or punitive measures.

(5) The house shall be free from accumulated dirt, trash and vermin.

(6) Meals shall be planned and prepared for adequate nutrition, and for diets if directed by a physician.

(c) (1) The provider shall be at least 18 years of age and in good health at the time of initial application for registration. A written statement must be received from a physician, nurse practitioner, or physician's assistant stating that the applicant and the members of the applicant's household are free of any infectious or communicable disease or health condition and are physically and mentally healthy. Such statements shall be renewed every two years.

(2) The provider shall not be totally dependent on the income from the clients for support of the provider or the provider's family.

(3) A criminal conviction shall not necessarily exclude registration as an adult family home; but an investigation thereof will be made as part of the determination of the suitability of the home.

(4) The provider shall be responsible for supervision at all times and shall be in charge of the home and provision of care, or shall have a responsible person on call. Any such substitute responsible person shall meet the same requirements as the provider.

(5) The provider is responsible for encouraging the client to seek and utilize available services when needed.

(6) The provider shall comply with the requirements of state and federal regulations concerning civil rights and section 504 of the federal rehabilitation act of 1973.

(7) The provider shall assure that clients have the privilege of privacy as well as the right to see relatives, friends and participate in regular community activities.

(8) The provider shall keep client information confidential. The use or disclosure of any information concerning a client for any purpose is prohibited except on written consent of the client or upon order of the court.

(9) The provider shall maintain contact with an assigned social worker and shall allow the secretary and authorized representatives of the secretary access to the home and grounds and to the records related to clients in residence.

(10) The provider shall inform the social worker immediately of any unscheduled client absence from the home.

(11) The provider is responsible for helping clients maintain their clothing.

(12) The provider shall furnish or help clients arrange for transportation.

(13) The provider shall help a client arrange for emergency and regular medical care when necessary.

(14) The provider shall submit any information relating to the operation of the adult family home which is required by the secretary.

History: L. 1983, ch. 142, § 4; April 21.

39-1505. Same; assessing compliance; suspension or revocation of registration; unannounced inspections. (a) The secretary may enter an adult family home at any time determined by the secretary to be necessary for the purpose of assessing compliance with the requirements provided in K.S.A. 39-1504.

(b) If at any time the secretary determines that inadequate care is being provided to a client by an adult family home, the secretary may suspend or revoke the registration of the adult family home or provide protective services for the client in accordance with the provisions of article 14 of chapter 39 of Kansas Statutes Annotated or may take both such actions.

(c) Authorized agents and representatives of the secretary shall conduct at least one unannounced inspection of each adult family home during each year for the purpose of determining whether the adult family home is complying with the provisions of this act and applicable rules and regulations relating to the health and safety of the clients of the adult family home.

History: L. 1983, ch. 142, § 5; April 21.

75-5916. Office of long-term care ombudsman; definitions. As used in this act:

(a) "Ombudsman" means a person or persons responsible for carrying out the powers, duties and functions of the office of long-term care ombudsman.

(b) "Secretary" means the secretary of aging.

(c) "Facility" means an adult care home as such term is defined in K.S.A. 39-923.

(d) "Resident" means an individual kept, cared for, treated, boarded or otherwise accommodated in a facility.

History: L. 1980, ch. 291, § 1; July 1.

75-5917. Same; established within department on aging; long-term care ombudsman, appointment; subordinate officers and employees. There is hereby established under the supervision of the secretary of aging within and as a part of the department on aging an office of long-term care ombudsman, the head of which shall be the long-term care ombudsman. The long-term care ombudsman shall be appointed by the secretary of aging and shall be in the classified service of the Kansas civil service act. The secretary of aging shall appoint all subordinate officers and employees of the office of long-term care ombudsman, and all such subordinate officers and employees shall be within the classified service under the Kansas civil service act. Under the supervision of the secretary of aging, the long-term care ombudsman shall administer the office of long-term care ombudsman.

History: L. 1980, ch. 291, § 2; July 1.

75-5918. Same; duties and functions of long-term care ombudsman. The long-term care ombudsman shall: (a) Develop continuing programs to inform residents of facilities, their family members or other persons responsible for residents of facilities of their rights and responsibilities;

(b) provide the legislature, the governor and the secretary with an annual report relating to the needs of residents in facilities, including recommendations for meeting those needs;

(c) collect data for analysis to inform other agencies, the legislature, the governor, the secretary and the public of the needs of residents in facilities;

(d) promote cooperation among the various agencies concerned with the regulation of facilities, or providing services to residents therein, and the department on aging;

(e) provide information to agencies and others as required; and

(f) perform such other duties and functions as may be provided by law or as may be directed by the secretary of aging.

History: L. 1980, ch. 291, § 3; July 1.

75-5919. Same; ombudsman right of entry to facilities and access to patients. (a) An ombudsman is hereby authorized to enter any facility and any area within such facility at any time with or without prior notice and shall have access to the residents of a facility at all times.

(b) An ombudsman shall notify immediately the person in charge of a facility upon arrival and shall present appropriate identification.

(c) Residents shall have the right to request, deny or terminate visits with an ombudsman.

History: L. 1980, ch. 291, § 4; July 1.

75-5920. Same; ombudsman access to records and documents. With the written consent of the resident of the facility, guardian of the resident or next of kin of a deceased resident, an ombudsman shall have access to all records and documents kept for or concerning the resident. In addition, in assisting a resident of a facility, an ombudsman shall have access to all records and documents of the facility which are relevant to such assistance. An ombudsman shall have access to books, records and other documents maintained by the facility to the extent necessary to carry out the provisions of this act.

History: L. 1980, ch. 291, § 5; July 1.

75-5921. Same; confidentiality of information, records and reports; copies of reports relating to health and safety of residents forwarded to state officials; summary report and findings forwarded to facility. All information, records and reports received by or developed by an ombudsman which relate to a resident of a facility, including written material identifying a resident, are confidential and not subject to the provisions of K.S.A. 45-201 to 45-203, inclusive, and amendments thereto, and shall not be disclosed or released by an ombudsman except upon the order of a court, except the long-term care ombudsman shall forward to the secretary of health and environment and the secretary of social and rehabilitation services copies of reports received by the long-term care ombudsman relating to the health and safety of residents. A summary report and findings shall be forwarded to the facility, exclusive of information or material that identifies residents or any other individuals.

History: L. 1980, ch. 291, § 6; July 1.

75-5922. Same; ombudsman access to records and documents kept by department of health and environment and the department of social and rehabilitation services. An ombudsman shall have access to all records and documents kept by the department of health and environment and the department of social and rehabilitation services which relate to facilities and concern the following matters: (a) Licensure of facilities; (b) certification of facilities; (c) public funding reimbursement for care of residents of facilities; (d) utilization and medical review records; and (e) complaints regarding care of residents of facilities.

History: L. 1980, ch. 291, § 7; July 1.

AARP

TESTIMONY BEFORE THE HOUSE COMMITTEE ON
PUBLIC HEALTH & WELFARE, ACCESS TO
HEALTH CARE FOR THE MEDICALLY
INDGENT

Mr. Chairman; Members of the Committee:

You are to be commended on your decision to review and study all avenues on how to provide medical care for the indigent or the uninsured. The State Legislative Committee of the American Association of Retired Persons in Kansas is in total agreement.

The Association, at both the Federal and State levels, is concerned about the ill, frightened, medically indigent and the uninsured, and the effects of uncompensated care on the health care system.

Physicians, hospital, and other providers often turn away those who cannot pay, even during emergencies. Many states have hospitals that routinely dump emergency patients on public facilities without first stabilizing them. People have died, or been seriously injured because of such practices.

Kansas has specific high risk populations that are either medically indigent or at risk of impoverishment.

1. Older adults between the ages of 60 to 64 who are not emploued, cannot afford to purchase adequate coverage and are ineligible for Medicare;

2. Mid-life women between the ages of 45 to 65 in which many are either not in the work force, are in low paying jobs, or have had a change in marital status find cost to be the main deterrent in purchasing adequate health insurance;

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2-4-7

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

~~Vice President~~ Executive Director Cyril F. Brickfield *Executive Director*

3. Minorities, Migrant and seasonal farm workers THAT DO NOT have the financial resources to pay for adequate health care and suffer from a number of health problems far exceeding the general population as well as language, transportation, and other barriers;

4. The homeless in which an increasing number appear to be women and children, young people, and mentally ill persons;

and

5. Displaced farmers who have experienced farm losses due to the declining farm economy and cannot afford to maintain medical insurance and do not qualify for public assistance.

Health care providers who deliver much of the free care to persons without adequate financing are at a great disadvantage in an increasingly competitive health care marketplace. AARP realizes that hospitals must raise their prices to paying patients to cover the cost of chaity care. Then, when group purchases seek out low cost providers, public hospitals and others with a commitment to the poor, lose out because of their high prices. Private paying patients are then directed to lower cost hospitals leaving charity care providers with an even heavier burden.

The medically indigent, the uninsured, and the underinsured are in a giant lottery, gambling they'll stay well. What's unfair is that most do not have a real choice about playing; moreover, the stakes if they lose are precariously high because many will be pushed into official poverty if accident or illness of any magnitude occurs.

These problems point out that the health care system is not functioning for vulnerable portions of our population. Access to care and the support of public hospitals are the major issues that the state and federal governments must deal with.

AARP has always supported governmental efforts to deal with the health care financing problems of vulnerable groups.

We were and are active in advocating for Medicare, Medicaid, and state programs to provide what support there is for aged and the poor.

Unfortunately, these programs, which werenever adequate, have eroded over time. Medicare now pays only 45% of the elderly's health care bill, and Medicaid serves less than half of the poor population. The question is, "What can the states do to deal with these problems, particularly those of the indigent, the uninsured and underinsured poor?"

If a program for the medically indigent is to be established in Kansas, public policymakers must consider the types of taxes that would be used to support additional expenditures.

Doctors and other practitioners ever more readily, though still reluctantly, acknowledge there's now a two-class system of health care delivery. Unfortunately, the longer the bloc of the medically indigent is permitted to grow, the more final is the fact that duality is here to stay.

Kansas should study innovative financing programs. Ten states have adopted legislation requiring health insurance companies to form a pool through which high risk persons can obtain health insurance. In addition, the state should investigate the best method of encouraging small employers to band together and purchase insurance at low group rates or provide tas creditc for small employers who often do not offer coverage because of high premiums.

Kansas must ensure that persons of all ages have access to good quality care.

The Kansas State Legislative Committee of the American Association of Retired Persons thanks the Committee for this opportunity to testify.

HEALTH CARE FOR MEDICALLY INDIGENT

I. Explanation

A. 581,000 Kansans reported as Medically Indigent. 4% of Kansans over 60 years of age (16,491) have no health insurance. 11,663 between 60 and 64 have no insurance.

Consequences are many:

1. People postpone medical care until an emergency exists.
11. The uninsured use half as much health service as the insured.
111. The health delivery system must meet the cost of charity care.

B. Current Laws and Regulations.

Medicare and medicaid are the main sources of medical service payments.
A.F.D.C. and S.S.I. set standards for entitlements.
State has considerable jurisdiction over entitlement regulations.
Laws are needed to control dumping of charity cases.
Some entitlement program needed for the uninsured.

C. Information provide at interim hearings by:

The health coordinating committee, The Kansas Hospital Association, The Kansas Medical Society, Social and Rehabilitation Services, Health Systems Agency, A.A.R.P.

D. Contacts for advocacy to be undertaken when the legislature convenes. Discussions with legislators prior to the session.

II. Population Affected

1. All low income persons.
11. Specally at risk:
low income elderly
population 60-64
low income women 45-65
itinerant workers
minority poor
the homeless
the unemployed - farmers.

III. Intended Effects

Some provision must be made to improve the health delivery system for the target populations.

Social and Rehabilitation Services, Department of Aging, Department of Health and Environment should be chosen to address the problem.

Current bill will have no immediate effect. Long term effects in doubt.

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IV. Estimated Cost

Certain changes in entitlements calculated to cost the state $7 million.

V. Legislative History

This problem has never been addressed by the Kansas Legislature
Federal initiatives:
- Kennedy Durenburger Bill
- Bills by Edward Reyballs
  - C.A.R.E.
  - U.S. Health
- Support from:
  - Health Delivery Agencies
  - Advocates for Aged and Infirm and Family welfare.
- Plans from other states.

VI. Recommendations

1. Immediate re-examination of the use of Medicaid in Kansas.
11. Set priorities. Most needy must be served first.
111. Ample current research exists to provide guidelines for action.
IV. The state budget should reflect efforts to relieve the suffering.

Littlejohn 425-5

36	2014
Fiscal Note	Bill No.

1987 Session
February 3, 1987

The Honorable Marvin Littlejohn, Chairperson
Committee on Public Health and Welfare
House of Representatives
Third Floor, Statehouse

Dear Representative Littlejohn:

SUBJECT: Fiscal Note for House Bill No. 2014 by Special Committee on Public Health and Welfare

In accordance with K.S.A. 75-3715a, the following fiscal note concerning House Bill No. 2014 is respectfully submitted to your committee.

Enactment of this legislation would create a nine-member Commission on Access to Services for the Medically Indigent and Homeless consisting of three members of the general public and six legislators. Generally, the Commission would be empowered to study the availability and delivery of services to the medically indigent and homeless. The Commission would be abolished on December 31, 1989. Members of the Commission attending regular meetings or subcommittee meetings would be paid compensation, subsistence allowances, mileage, and other expenses as provided in K.S.A. 75-3223.

The fiscal impact of House Bill No. 2014 would depend upon a variety of factors not known at this time, i.e. the number of meeting days for regular sessions of the Commission, the number of meeting days for subcommittee meetings, and the geographical residence of the individuals selected for membership on the Commission. However, utilizing the compensation and subsistence allowances provided for in K.S.A. 75-3223, the cost for reimbursements to commission members for each day in regular session would total approximately $1,025. Assuming that the Commission would hold 12 two-day meetings throughout the course of its deliberations and assuming an average round trip mileage of 250 miles for each member, the cost for reimbursements to commission members would total approximately $30,100. It has been assumed that this amount would be financed from the State General Fund.

Additional expenditures resulting from the passage of House Bill No. 2014 would be in addition to those amounts included in the FY 1988 Governor's Budget Report.

Gary L. Stotts
Acting Director of the Budget

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att. #6
2-4-87

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WRITTEN COMMENTS
PUBLIC HEARING REGARDING
HOUSE BILL No. 2014

SUBMITTED
FEBRUARY 4, 1987
BY
BARBARA J. GIBSON
FOR THE
STATEWIDE HEALTH COORDINATING COUNCIL

On July 23, 1986 the Health Coordinating Council adopted the report of the Committee on Access to Health Care for the Medically Indigent. The report entitled "The Medical Indigency Crisis in Kansas" which has been one of the most requested reports produced by the Council, had two major recommendations; both have come to pass.

The first recommendation was that the 1987 legislature assign the indigency issue to a Special Interim Committee for study. The Interim Committee was instructed to examine the issue and to attempt to determine the size, causes and potential solutions to the problems identified; and to coordinate the Committee study under Proposal No. 24 with the Statewide Health Coordinating Council study on access to care. The Special Committee prepared a report recommending that "continuing attention be given to the problems of medical indigency and uncompensated care because members believe that failure to do so will result in decreased access to health care, both geographically and financially, for a growing number of Kansans." The Health Coordinating Council whole-heartedly supports this belief.

The second recommendation of the Coordinating Council was addressed by the implementation recommendation of the Interim Study Committee and resulted in drafting House Bill 2014 which creates a Commission on Access to Services or the Medically Indigent and the Homeless. The Statewide Health Coordinating Council fully supports this bill and urges expedient adoption and implementation.

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Attm. #1
2-4-7

LAWRENCE-DOUGLAS COUNTY HEALTH DEPARTMENT

336 Missouri, Suite 201
Lawrence, Kansas 66044-1389
913-843-0721

TESTIMONY ON HOUSE BILL 2014

Presented February 4, 1987

by

W. Kay Kent, R.N., M.S.
Administrator/Health Officer

House Public Health & Welfare Committee

I support House Bill No. 2014.

In Douglas County and in Kansas there are citizens who lack private or third-party coverage and who lack the personal resources to pay for their health care.

Our health department provides preventive services to the medically indigent, i.e. Immunizations, Family Planning, Prenatal Care, Women Infants and Children Supplemental Nutrition Program (WIC) and Health Screenings. We do not provide acute illness care. We are frequently contacted by individuals who need acute illness care but lack the financial resources to obtain that care. These individuals need to receive care early in their illness so as to prevent suffering and more expensive medical costs.

I believe H.B. No. 2014 is needed so the problems of the medically indigent and homeless will be addressed.

Attached is additional information on the issue.

PH&W
Attm. # 8
2-4-7

LAWRENCE-DOUGLAS COUNTY HEALTH DEPARTMENT

336 Missouri, Suite 201
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TESTIMONY TO SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE REGARDING ACCESS TO HEALTH CARE FOR THE MEDICALLY INDIGENT

Prepared by W. Kay Kent, R.N., M.S., Administrator/Health Officer

I want to first talk about the services our Health Department provides to the medically indigent and why these services are so important. Secondly, I want to share with you some of the problems we are currently seeing regarding access to acute illness care for the medically indigent.

Services of our health department are aimed at prevention. Some examples of our preventive services are:

Immunizations

- Childhood immunizations prevent many serious diseases and the permanent physical and mental handicaps they may cause.
- Influenza vaccine program prevents excess mortality in the elderly and chronically ill.
- Pneumonia vaccine program prevents pneumonia and death in the elderly.

The poor are of particular concern since survey data indicates they consistently have lower immunization levels and higher disease incidence.

WIC - Women, Infants and Children Supplemental Nutrition Program

- Maternal nutrition is critical for infant health. Pregnant women lacking proper nutrition have a greater chance of bearing either a low birth weight infant (often require very costly intensive care) or a stillborn.
- WIC is cost effective. Studies have shown that for every $1.00 spent on WIC, $3.00 is saved.

Family Planning

- Family planning as a preventive health measure supports:
  - maternal and infant health;
  - the emotional and social health of individuals and the family.
- Family planning helps avoid unintended pregnancies (unplanned births are almost twice as frequent in poor as compared to non-poor families). Wanted births are one basis for development of strong families.

- National studies have shown that family planning is the most effective intervention in reducing infant mortality. (Pregnancies among teenagers, among women who are unmarried, among women over the age of 35 and among women who have had several pregnancies are all associated with higher than average rates of maternal and/or infant morbidity and mortality).

- Family planning services reduce child abuse.

- Family planning helps prevent the slide into poverty.

- Family planning is cost effective. Studies have shown that for every $1.00 spent, $2.70 would be saved in government health and welfare spending in the subsequent year alone.

Maternal and Infant Program

- High quality early and continuous prenatal, birth and postnatal care can decrease a newborn's risk of death or handicap from pregnancy complications, low birth weight, maternal infection from sexually transmitted disease and developmental problems, both physical and psychological.

Health Screening Clinics for the Elderly

- The Health Department's screening can have great value in the early detection of problems which, if left undiagnosed and untreated, could lead to severe handicap (e.g. glaucoma, hypertension, some types of anemia, depression, hearing disorders, diabetes, some cancers and over-medication.)

Other preventive services include:

- **Blood pressure screening and education** for the early detection of hypertension as well as education concerning high blood pressure management.

- **Sexually transmitted disease screening and treatment** to prevent the spread of the disease and to prevent complications of pelvic inflammatory disease, infant pneumonia, infant death, birth defects and mental retardation.

- **Well child examinations** for the purpose of early detection of abnormalities, prevention of health problems and health education regarding normal development.

- **Healthy Start home visits** to provide support to enhance parenting skills and to provide information on preventive health care services in the community.

- **Case management services for the frail elderly** to promote health and independent living for the elderly through the coordination of health and social services.

The majority of individuals we serve are poor or the working poor and do not have the financial means to receive the preventive services elsewhere. Without public funding for these preventive services, the cost to the State would be much greater in terms of medical and welfare costs.

Acute Illness Care Gaps

The Health Department does not provide acute illness care. Yet, we are frequently contacted by and/or in contact with individuals who need acute illness care but lack the financial resources to obtain care. Examples are:

- Infants and children with rashes; earaches/ear infection; fevers; diarrhea.
- Women with abnormal pap smears; pelvic inflammatory disease, which require diagnosis and treatment.
- Individuals with high blood pressure who need diagnosis and treatment.
- Individuals with symptoms of urinary tract infection.
- Individuals who can't afford medications, especially the elderly who may be on blood pressure medications and have monthly medication costs of $50 to $100. Some of the elderly seen in our health screening clinics have medication costs of $200 monthly.

These individuals need to receive care early in their illness so as to prevent suffering and more expensive medical costs. However, I do not believe we should develop two standards of medical care--one for the medically indigent and another for the non-medically indigent.

TESTIMONY ON HB NO. 2014
by
Sister Ann Marita Loosen, SCL
President, St. Francis Hospital and Medical Center
Topeka, Kansas
Representing Catholic Health Association of Kansas
February 4, 1987

My name is Sister Ann Marita Loosen and I am President of the St. Francis Hospital and Medical Center here in Topeka. I am appearing before you today, representing the Catholic Health Association of Kansas. Our members include 18 Catholic hospitals in Kansas and 7 nursing homes, as well as Sister sponsor organizations.

We support House Bill No. 2014 to create a commission on access to services for the medically indigent and homeless. The proposed commission's responsibilities are major, and are very timely now, because there are thousands of people in Kansas who are denied access to health care today more than ever before. They include the unemployed, the uninsured, and those no longer eligible for Medicaid or Medi-Kan. The list is growing daily. We are concerned about these people. Our hospitals do not wish to deny them admission for lack of funds or insurance, but we are concerned that we may not be able to provide this care adequately in the future, unless we find support from local and state government. Because of the

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attm #9
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changing financial regulations we are no longer able to shift the cost for those unable to pay. In 1986 at St. Francis Hospital and Medical Center our care for the poor doubled. So far in this fiscal year we see that same pattern continuing.

Hospitals are probably the only entities where people can receive service without paying in advance. If you go to a grocery store, you need to be able to pay for groceries before leaving the store -- the same holds for clothing stores and furniture stores, yet in hospitals we have given service and are expected to give that care whether or not patients have the money or insurance to cover such care.

We understand that this is a complex subject, one which was partially studied by the special committee on Public Health and Welfare this last summer. This committee came to the same conclusion as we have, and I quote from their interim report:

> "...there is a problem which is rapidly approaching major proportions in securing access to health care for those Kansas citizens who lack private or governmental third party coverage and who also lack the personal resources to pay for all or a part of their health care..."

We agree with the committee's further conclusion that, again quote,

> "...an additional commitment must be made to the indigent...and the homeless and the medically indigent."

We support HB 2014. We believe this to be appropriate for the following reasons, and urge your favorable consideration:

1. The commission will be able to spend the required time to study this issue and report findings of use to the governor and the legislature.

2. The commission, made up of legislative as well as several public members, will provide for legislative inter-action and consultation, to help in eventual, hopeful, positive, legislative action.

Thank you for your courtesy and interest.

END

STAR FORUM

KC Star-Times 1/25/87

Ill, frightened, and uninsured

The medically indigent need help

By Jean Haley
a member of the editorial staff

In southwestern Kansas, Tom Lee knows people in his community whose insurance would make them financially fit for a heart transplant. But if pneumonia puts them in the hospital for a few days, they're in big trouble. The whole bill comes out of their pockets.

Lee is the administrator of a 13-bed district hospital in Satanta, a town of about 2,000 people three quarters of an hour from Garden City. The national issue of the uninsured and under-insured patient is as vivid in that farm and ranch country as it is in Kansas City. In 1985, the Satanta District Hospital with an annual income of $1.4 million gave about $75,000 worth of uncollected care. It's expected to be about the same for 1986.

Caught are the hired hands who have a job but no insurance benefits from the landowner. Also struggling farmers scrutinizing their expenses and sacrificing items they didn't use last year. Health insurance often is a candidate. If they don't eliminate it, they may cut way back so they have a $2,000 deductible.

"It's not really health insurance," Lee admitted. "It's catastrophic insurance."

The Satanta hospital is supported by a tax levy, so unpaid bills already are being borne by the taxpayer. But increasing debts at rural facilities are not just local or private business. James Behan, chairman of the Kansas state legislative committee of the American Association of Retired Persons, cited it as a major worry of the organization. If a rural hospital closes, he pointed out, the doctors go. The result can be that everyone loses access to health care, the rich and insured as well as the marginal. And for the elderly that is a particularly frightening prospect.

It's only one chain becoming increasingly visible as the matter of people with no health insurance draws the attention of Congress as well as state legislators. Basically this is not a welfare issue. But it is a public policy question. The segment of the population involved is primarily an employed group, newly needing charity, caught in a one-time problem or an emergency.

About 37 million Americans now have no health insurance. That's about the population of the 43 largest cities in this country, a new subclass which has been growing by nearly a million persons a year since 1979. Yet Medicaid, the government insurance program, covers a smaller proportion of the poor than it did in 1975, less than half today compared with 63 percent then. On top of that, the number of poor people has been inching up since 1979.

The uninsured are in a giant lottery, gambling they'll stay well. What's unfair is that most do not have a real choice about playing; moreover, the stakes if they lose are precariously high because many will be pushed into official poverty if accident or illness of any magnitude occurs.

About three-fourths have a job or are dependents of an employed person. Additional reasons for being one of those statistics include having a high-risk ailment that makes them ineligible for private insurance; being unemployed after half a lifetime in a recently obsolete industry; being forced into premature retirement which also cuts off their families, and being a few years shy of Medicare.

It must be remembered that this

group of 37 million Americans is outside eligibility for Medicaid, the state-federal program subsidizing health care for the poor. It is also outside Medicare, which serves the elderly and any private insurance coverage. It is a group re-living "the good old days" when the patient was directly responsible for paying medical bills, one incentive for people to avoid doctors and hospitals as long as possible. The tragic flaw is that costs of all health care, even the most rudimentary basics, have blossomed to include the most modern technology and sophisticated procedures. It's an element in the cost leaps that has far surpassed general inflation for many years. People don't have the option of not participating in exotic medical advances as patients. Yet many don't have the money to pay for them.

Congress will look at the issue. Several major pieces of legislation were filed last year, but went nowhere. It's expected that sponsors will try them again. There's good cause to believe one reason Sen. Edward Kennedy chose to become chairman of the Labor and Human Resources Committee instead of the more prestigious Judiciary was to press ahead on his health agenda. Fresh testimony has already been taken this month on the issue of the uninsured at the committee's public hearings. Whether it might be addressed alone or be meshed with other volatile questions—from AIDS to nursing home coverage—in a renewed proposal for a real national health insurance scheme is uncertain.

Last year, Kennedy was the lead sponsor on proposed equal access legislation. It mandated states to set up risk pools to cover their underinsured and uninsured populations. A complementary bill would have employers who provided insurance benefits paying into the risk fund. One reason the bill died was that it seemed to penalize those employers behaving most responsibly. Something similar likely will be re-introduced. In the House, there may be measures dealing with questions of nursing care compensation, malpractice and access to health care. If the cause gets taken seriously, however, it's likely activists will join the Kennedy parade.

The truth is, 37 million people are a worry. The cumulative effect of story after story is to validate the gap and the helplessness of victims. What's told about Truman Medical Center's anxious budget meetings with the city, the bills of tens of thousands of dollars at Children's Mercy that ordinary parents can't pay in a lifetime, an elderly couple's life savings wiped out with one illness, the farmers and single-parent families and service workers without insurance protection ought to disturb Congress and state legislators. But as we usually do, we will fight first over how to pay for something before setting policy or outlining a service to fit a need. The budget is a mess so Washington has a fine excuse for doing nothing.

"I think there's a lot of support, but the question is can anybody come up with a bill that doesn't cost much?" reflected one of Rep. Richard Gephardt's staff members. "Everybody wants to do it. There's a number of things that are going to come up, but the real question is funding."

Gephardt has been particularly interested in the ticklish health care issues. He still is. But apparently he—like everyone else—is waiting for something tangible from the

The uninsured are in a giant lottery, gambling they'll stay well. What's unfair is that most do not have a real choice about playing; moreover, the stakes if they lose are precariously high because many will be pushed into official poverty if accident or illness of any magnitude occurs.

Kennedy committee to deal with the uninsured patient issue.

For now, if not from now on, the dilemma apparently is a state and local one. After all, it's the Satanta District Hospital which has to send its convalescing gall bladder patients to the local bank for a loan. It's Kansas City being asked to come up with an extra $3.4 million next year to support Truman Medical Center. It's Missouri being blamed for not taking care of the medically indigent.

According to an Intergovernmental Health Policy Project report published a little more than a year ago, access to health care for the medically indigent has become an urgent issue in the 1980s. The recession, federal and state cutbacks in other programs for the indigent and a lingering unemployment dwarf current state efforts. In addition to Medicaid, on which the states spend more than $16 billion a year, 34 states have supplementary indigent care programs of some sort, although some are so limited they barely deserve the name. These states, and counties acting as their agents, have spent more than $2.3 billion on 41 separate programs. But there seems to be no catching up. Since 1984, nearly half the states have set up legislative or gubernatorial study commissions related to financing indigent care. Kansas is one. Its study is still in the exploratory stage.

The Missouri General Assembly will look at a solution during this session. Nothing quite like it is being tried elsewhere.

Described as "a helping hand, not a handout," the new program called MedAssist would be created for the uninsured and catastrophically ill if a bill introduced by Reps. Carole Roper Park, Jerry Burch, Russell Brockfield and Gail Chatfield were approved. MedAssist is a hybrid, mixing elements of private insurance and government programming with the individual ability-to-pay concept. Sponsors describe it as a quasi-government agency with the powers of an insurance company.

The money for it would come from two sources. Primary funding would be from a new 1-cent sales tax. Approval would require a majority vote. It's estimated such a sales tax would raise $360 million annually.

Instead of being used as a government subsidy for another entitlement program, however, these funds would supplement what participants pay. Their premiums would be based on their ability to pay; there would be deductibles and co-payments as in private insurance. Moreover, the legislation creates a "contribution defined" benefit plan. What's offered is to be based on revenue collected.

The governing board designs the

See Insurance, pg. 6E, col. 4

(5) (6)

Insurance *continued from pg. 1E*

benefit package as well as adjusts participants' costs to fit the revenue.

Last year the General Assembly looked at a similar concept to treat the uninsured but it was considered too broad and too expansive. Over the summer a committee of legislators, providers and advocates, labor and business representatives hammered out a new bill. Among the changes sponsors feel will make MedAssist more palatable are ones establishing tougher income eligibility levels, the tying of benefits directly to revenue, provisions for deductibles, flexibility on coverage limits and numerous management regulations.

On other social issues of recent memory—child car safety restraints, for example—Missouri has had good ideas ahead of the pack but dawdled in passing legislation, being one of the last states to finally get a new law. It may well be the course of this health proposal, in spite of public and business support. But whether it's this or another method, Missouri cannot ignore its medically indigent subgroup, between 500,000 and 600,000 with no insurance and another 300,000 with inadequate insurance. Neither can the rest of the nation.

"About 30 states require local governments to fully or partially fund indigent care programs," according to a 1986 report by the National Conference of State Legislatures which identified the public hospital as one such program. "As health care providers of 'last resort,' public hospitals bear an increasingly disproportionate share of uncompensated care, accounting for 10 percent of total hospital charges nationwide but 35 percent of uncompensated charges. Although a marked decline in total hospital use has occurred nationally over the past two years, public hospital use has increased an average of 10 percent over the same period."

Doctors and other practitioners ever more readily, though still reluctantly, acknowledge there's now a two-class system of health care delivery. Unfortunately, the longer the bloc of the medically indigent is permitted to grow like Topsy, the more final is the fact that duality is here to stay.

CHILDREN'S COALITION

P.O. Box 5314
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TESTIMONY OF LYNN BARCLAY

ON HB 2014

before House Public Health & Welfare Committee
February 4, 1987

The Children's Coalition supports HB 2014, a bill that would create a Commission on Access to Services for the Medically Indigent and the Homeless.

We support the commission responsibilities listed in the bill for these reasons:

1. Kansas needs more information on the scope and nature of the medically indigent and homeless population to make informed decisions on policies and appropriations.

2. The health care delivery system for poor people in Kansas is a complex mix of Medicaid, Medikan, Primary Care Networks, private physicians, local health departments, and public and private hospitals. An independent commission could help assess and coordinate this system.

3. The specific health care needs of children and pregnant women could be addressed by such a commission. For example:

   a. Kansas could ultimately save state (and federal) dollars by investing in preventive prenatal care, which costs about $500-$700 per case. In the absence of such care, babies requiring neonatal intensive care cost the Medicaid budget an average of $15,000 per case. The commission could identify and advocate for cost-effective use of the existing dollars we spend on indigent health care.

   b. Congress has enacted a series of laws that give states the option of making several significant Medicaid improvements for poor pregnant women and children age 0-5. (The options are described in the attachment.) Kansas should seriously consider taking advantage of these options and the federal dollars that accompany them. The commission could take the lead on such an assessment.

   c. Currently less than half of the children eligible for EPSDT in Kansas are enrolled in the program. EPSDT is a successful preventive health care program for Medicaid-eligible children and the federal government will pay 54% of the cost in FY 88. The commission could pinpoint ways to get more children enrolled in EPSDT.

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CHILDREN'S COALITION

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NEW FEDERAL MEDICAID OPTIONS THAT WOULD HELP KANSAS CHILDREN

January 1987

The 99th Congress enacted a series of laws that give states the option of making several significant improvements in Medicaid for pregnant women and children. These reforms were passed at the urging of the National Governors Association.

A. PRESUMPTIVE ELIGIBILITY

1. Provisions--Local health departments (and certain other providers) can presume a pregnant woman is eligible for Medicaid, based on a simple income test, and immediately give her outpatient prenatal care for up to 45 days.

2. Advantages

   a. Reduces delay. Pregnant women need to enter prenatal care promptly and should not have to wait up to 45 days for SRS to process their Medicaid application.

   b. Reduces red tape for patient who could get both her temporary Medicaid card and her health care at the same location.

   c. Simplifies screening since the pregnant woman's temporary eligibility can be based solely on her oral affirmation of income.

   d. Draws in more federal money. Many local health departments are already serving large numbers of these women without federal matching funds. Current state and local expenditures could be matched under this program.

   e. No error rates would be imposed by the federal government if services were paid for and the woman was ultimately found to be ineligible.

B. EXTEND MEDICAID COVERAGE

1. Provisions--Extends automatic Medicaid coverage to pregnant women and children 0-5 whose family incomes exceed state ADC payment levels but are less than 100% of federal poverty line.

2. Advantages

   a. Improves birth outcomes for large numbers of poor pregnant women. (ADC payment level is less than $\frac{1}{2}$ federal poverty line.)

   b. Improves health of large numbers of poor children.

   c. Draws in more federal money. Certain state and local dollars currently being spent by local health departments for these women and children could be matched with federal Medicaid funds.

   d. Can be phased in by, e.g., covering only children age 0-2 or only up to 80% of federal poverty line.

KANSAS NOW NATIONAL ORGANIZATION FOR WOMEN

Wednesday February 4, 1987

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE ON PUBLIC HEALTH AND WELFARE, THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY. I AM GAIL HAMILTON, KANSAS NATIONAL ORGANIZATION FOR WOMEN. ON BEHALF OF THE MEMBERS OF KANSAS NOW, I ASK THAT YOU SUPPORT HB 2014.

As reported by legislative staff to your committee a few weeks ago, there is a growing number of persons in Kansas who lack access to health care services, to housing, to jobs, to child care and to other opportunities that might improve the situation in which they find themselves.

The interim sutdy identified that we do have a problem of medically indigent and homeless in our state. The information generated from the study needs to be utilized now to solve these problems.

A statement from Time magazine, December 29, 1986 has stayed with me and applies to the decision before us now. Roger Rosenblatt writes in his Letter to the Year 2086, and I quote, ". . . the plight of the poor is a constant subject of concern and speculation, arising regularly in the platforms of both political parties and in public debate. Below the glacial surface of inactivity, real hearts stir on this issue, but they move nothing. This secret of the age has a secret of its own: we embrace all groups but the poor."

Let's move past the public debate and the stirring hearts and improve these situations we have identified. I therefore urge you to pass HB 2014. Thank you.

PH
att. # 11
2-4-7

KCOA
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DEDICATED TO THE IMPROVEMENT IN QUALITY OF LIFE FOR ALL KANSANS

TESTIMONY ON H.B. 2014
MARK INTERMILL
KANSAS COALITION ON AGING

My name is Mark Intermill. I am the director of the Kansas Coalition on Aging. I am here today to support H.B. 2014.

This bill addresses two major problems facing our state; homelessness and medical indigency. It is the latter that I would like to address today. KCOA has identified control of health care costs and assurance of access to health care services as a major concern of older Kansans. Older Kansans, as a group, utilize health care services to a greater degree than do other age groups. Despite the availability of Medicare, older persons spend the same proportion of their incomes on health care as they did prior to the enactment of Medicare.

The crisis in health care has had the greatest impact on people with low incomes. Medicaid is the primary mechanism for financing medical care for the poor. In Kansas, older persons have the highest poverty rate of any adult age group. The poverty rate of older persons, in Kansas, is the same as that of children. Despite their relatively high poverty rates, only 36% of the elderly poor who do not live in institutions qualify for Medicaid.

While older people are affected by the rising costs of health care, the medical indigency issue is by no means an aging issue. In fact, the existence of Medicare provides limited protection against rising health care costs. Groups which may be at greater risk of medical indigency are the unemployed, persons who cannot afford to purchase health care insurance, widows or divorcees who suddenly lose insurance coverage which had been provided by their spouse's employer, early retirees who are not yet eligible for Medicare and families who must deplete their life's savings to pay for catastrophic illness.

As health care costs increase, more people will be priced out of the health care market. Many of the jobs created during this decade have been low-paying service jobs with few or no benefits. While we do not have Kansas statistics, nationwide approximately 16% of the nonelderly population do not have any health insurance. Even having health insurance does not assure coverage of health care costs. The Conference on Alternative State and Local Policies found that commercial health insurance policies leave health consumers to pay 60% of their total health costs.

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It is especially important for Kansas to address the medical indigency question. The health care cost inflation rate in Kansas has increased faster than the national rate. In the period from 1966 to 1982 health care costs in the United States increased 507%. In Kansas, the inflation rate for the same period was 614%, higher than any of our neighboring states. Only eleven other states have had a greater increase in health care costs during that period.

While we would have liked to have had action on this issue during this session of the legislature, we recognize that the fiscal crisis facing the state probably precludes substantive action at the present. We do support this legislation as a first step towards addressing this very critical problem.