Approved 2-24-87
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

10:00 a.m./~~p~~m. on February 20, 1987 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Norman Furse, Revisor of Statutes Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
Charles Hamm, Assistant to Secretary of Health and Environment for Kansas
John Schneider, Commissioner for Income Maintenance & Medical Programs, SRS
Lois Johnson, McDonald, Kansas
JoEllen Androes, The Lorraine Center, Wichita, Kansas
Basil Covey, Kansas Retired Teachers Association, Topeka, Kansas
Mark Intermill, Director, Kansas Coalition on Aging, Topeka, Kansas
Keith Landis, Christian Science Committee on Publication for Kansas, Topeka, Kansas
Gail Hamilton, Kansas National Organization for Women, Topeka, Kansas
Donald F. Rowland, J.D., Washburn University School of Law, Topeka, Kansas
Wanda Blazer, R.N., President, Alzheimers Disease and Related Disorders Association, written testimony only

Others attending: see attached list

Charles Hamm, Kansas Department of Health and Environment appeared before the committee to request the introduction of a bill relating to preschool children and reporting certain conditions to the Secretary of Health and Environment. (attachment 1)

Senator Hayden moved that the committee introduce this bill. Senator Mulich seconded the motion. The motion carried.

John Schneider of SRS testified and presented written testimony by Robert C. Harder, Secretary, Social and Rehabilitation Services. Mr. Schneider stated that while the department was supportive they could not support the division of income provisions because it would violate federal statutes and regulations. A potential fiscal impact statement of SB-264 amd Exempted Resources statement are a part of the written testimony. (attachment 2)

Lois Johnson testified and presented written testimony in support of SB-264. Mrs. Johnson related her personal experiences to the committee. (attachment 3)

JoEllen Androes testified and presented written testimony supporting SB-264. Ms. Androes related experiences in dealing with Alzheimer patients and told the committee these victims and their spouses are in great need of help. (attachment 4)

Basil Covey spoke in support of SB-264, stating that there is statewide support for this bill in order that both spouses will not eventually be on Medicaid. (attachment 5)

Mark Intermill spoke of statewide support for SB-264, and urged the committee's support. He stated that concerns about the cost of the program were real but questioned whether a policy which would eventually place 2 people rather than one on Welfare was a proper one.

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10:00 a.m./~~p.m.~~ on February 20, 1987

Keith Landis appeared to state concerns about Section 4 (page 7) of SB-264 as it would affect Christian Scientists and their beliefs. (attachment 6)

Gail Hamilton told the committee that Kansas Now supported SB-264 for two major reasons, one being that the fastest growing segment of people are those age 65 and over; the second would be that the spousal impoverishment disproportionately affects women. (attachment 7)

Donald F. Rowland stated that at present the choice in Kansas as far as division of assets is concerned is either divorce or abject poverty. The federal law will eventually be determined in the court system. (attachment 8)

Written testimony by Wanda Blazer urged the committee to support SB-264. (attachment 9)

The next committee meeting will be held at 10:00 a.m. February 23, 2987, in room 526-S.

The meeting adjourned at 10:58 a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-20-87

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Ann Allsbury - Topeka	KS Dept of Health & Env.
Charles V. Hamm - Forbes Field - Topeka	KDHE
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Lizzie Young Forbes Field - Topeka	KDHE
Marguerite B. Chalmers	GDRDG Topeka
Fern Gray	" "
Wanda Blaser	ADRDA Topeka
John Schneider D.S.O.B.	SRS.
Dawn Priest	SRS
Doug E. Peterson	SNL Manhattan
Lois Johnson	ADRDA Colby
Oleta Huston	ADRDA El Dorado
Linda Wright	ADRDA Overland Park
Jay Hoffman	ADRDA Overland Park
Carolyn Baxter	ADRDA Topeka, Kansas
John W. Briery 336 SE 45th Topeka, KS	ADRDA " "
Marcella Briery "	ADRDA " "
Kevin D. McFarland	Ks. Assoc. of Homes for Aging
Gail J. Hamilton	KS N.O.W.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2/20

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Robert C. Guthrie	Topeka Ks.	ADRDA Topeka Chapt.
Mark Intermill	Topeka, Ks.	Kansas Coalition on Aging
DICK HUMMEL	TOPEKA KS	Ks. HEALTH CARE ASSN
Carl Shankland	Topeka KS	Mature Outlook Topeka.
Mary Jane Shankland	Topeka Ks	Mature Outlook Topeka
Dean Teske	Wheaton Ks	Private
PAT DONAHUE	TOPEKA, KS	KANSAS LEGAL SERVICES, INC.
John O. Miller	Topeka	AARP
Basil Covey	Topeka	KRTA
Jo Andrews	Wichita	The Lorraine Center
Don Reinhardt	Topeka	Washburn Law School.
Mary Gibson	Topeka	AARP
Molly Daniels	Topeka	Ks Dept on Aging
Lyndon Drew	Topeka	KDOA
Brenda Stapp	Topeka	KDOA

_____BILL NO._____

BY_____

AN ACT concerning preschool children; relating to reporting of certain conditions of such children to the secretary of health and environment.

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

Section 1. As used in this act:

(a) "Handicap or chronic condition" means a physical handicap or chronic disease which will hinder the achievement of normal physical growth and development.

(b) "Mental retardation" shall have the meaning as is ascribed to such term by K.S.A. 76-12b01 and amendments thereto.

(c) "Physician" means a person licensed to practice medicine and surgery.

(d) "Secretary" means the secretary of health and environment.

Sec. 2. The secretary of health and environment shall supervise the reporting of any medically diagnosed condition of a preschool child under six years of age that indicates mental retardation or a handicap or chronic condition. Except as otherwise provided in this section, every primary care physician who has primary responsibility for treating a child with such a diagnosed condition shall report the case to the secretary of health and environment on forms provided by the secretary. Permission to make such report shall be obtained from the child's parent or guardian prior to making the report. No report shall be made unless such permission has been granted by the child's parent or guardian. The purpose of this reporting is to collect and compile complete and accurate information concerning the number of preschool children within the state who have handicapping or chronic conditions in order to plan for and make avail-

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Attachment 1

able services to these children and their families. This information will be used only as aggregate data for research and statistical purposes and shall not be used to identify a child without permission from that child's parent or guardian.

Sec. 3. Any physician who reports in good faith and without malice, or who in good faith and without malice fails to report, the information required to be reported under this act shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such report. Any such person shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

Sec. 4. Information obtained by the secretary under this act is confidential and shall not be disclosed except as provided in this section. The secretary may disclose information obtained under this act: (a) Upon the consent, in writing, of the person who is the subject of the information, or if such person is under 18 years of age, by such person's parent or guardian; or (b) upon the request of an organization or individual conducting a scholarly investigation for legitimate research or data collection purposes, so long as such information is disclosed in a manner which will not reveal the identity of the persons who are the subject of the information or the identity of the physician reporting such information. The secretary may disclose information obtained under this act to officers and employees of the department of education who are designated by the state board of education to receive such information. Officers and employees of the department of education who receive such information shall be subject to the same duty of confidentiality as the secretary with respect to such information.

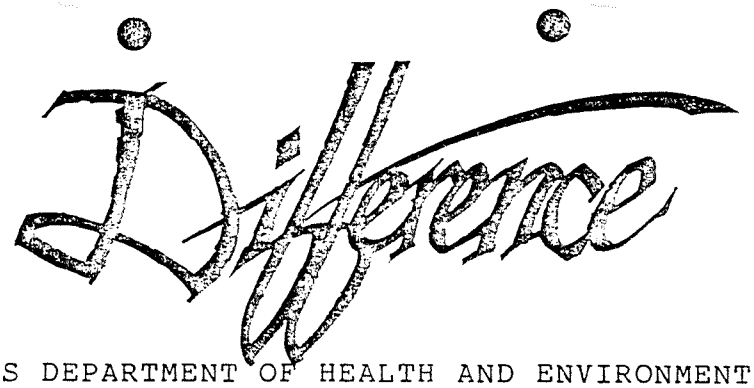
The secretary shall remove the records of a child whose parent or guardian requests in writing such action.

Sec. 6. Any person, association, firm, corporation, organization or other agency willfully or knowingly permitting or encouraging the disclosure of information obtained under this act and not otherwise authorized to be disclosed under this act shall be guilty of a class C misdemeanor.

Sec. 7. Nothing in this act shall be construed or operate to empower or authorize the secretary to restrict in any manener the right of a physician to recommend a mode of treatment for mental retardation, handicaps or chronic conditions or to restrict in any manner an individual's right to select the mode of treatment of such individual's choice.

Sec. 8. The secretary may adopt rules and regulations necessary to carry out the provisions of this act. The rules and regulations shall include, but shall not be limited to, the following: (a) Procedures for reporting under this act; (b) procedures for review and follow-up on the case records of a child; (c) procedures for the protection of the confidentiality of information obtained under this act; (d) with appropriate medical consultation an enumeration of handicapping or chronic conditions to be reported under this act; and (e) procedures for obtaining permission from parents or guardians to make the report and for use of information obtained in the report.

Sec. 9. This act shall take effect and be in force from and after its publication in the statute book.



KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

PROPOSED TESTIMONY

January 21, 1987

BACKGROUND INFORMATION:

In June, 1983 Governor Carlin formed a task force on preschool children with handicaps. The thirteen appointees received testimony from citizens and service providers across the state and conducted other research on the needs of preschool children with handicaps and their families. Based on information received, the task force submitted its recommendations to the Governor in March, 1984. In April, 1984 the Governor appointed a Cabinet Subcommittee on Early Childhood Developmental Services that was instructed to implement the recommendations of the task force.

One of the recommendations of the task force was for the development of a statewide strategy for the early identification and follow-up of developmentally delayed children. The concept of early identification and follow-up was also endorsed by members of the general public who attended six town meetings held throughout the state in September, 1985.

The rationale for collecting this information is to aid in coordinating the services of preschool children with handicaps throughout the state. Sound research clearly shows that early intervention results in significant movement from special education into regular education, and regular education costs less.

Based on Kansas 1984-85 figures, serving a child with a handicap from birth through age 18 is estimated to cost $71,033. The costs are higher when intervention begins at age 3 -- $72,157. The costs accelerate to $79,663 when intervention waits to age 6. The cost difference between beginning at age 3 and waiting until age 6 is $7,507 per child. Cost savings at birth - $8,600.

When facing a similar proposal, the Colorado legislature asked for an analysis of the financial payoffs. The study displayed amazing results: in three years time, cost savings would begin to be realized. Analysis showed that approximately one-third of the children entering kindergarten each year would no longer need special education. This obviously results in a net savings of tax dollars.

This Bill as introduced provides for the reporting of information to be used for planning, research and service development by requiring physicians to identify children who have handicaps. Unless parental consent is obtained, no information is collected. The committtee members are reminded that overriding this legislation is the Family Rights & Privacy Act, which also prohibits disclosing any information without parental consent.

DEPARTMENT'S POSITION:

The Kansas Department of Health and Environment as does the Coordinating Council supports this Bill. This bill facilitates the collection of data that will ultimately assist parents in locating services for preschool children with handicaps.

January 21, 1987

These figures are from last year, but feel figures will remain much the same.

Fiscal Impact:

For FY 87 start-up costs are covered by federal grant funds. In FY 86 if further federal grant funds are not obtained, maintenance costs would be as follows:

Printing and mailing of forms	$ 609
Computer time and storage	$ 672
Staff time will be absorbed	0
Total	$1281

Figures are based on reporting of 4500 children per year.

[As Amended by Senate Committee on Third Reading]

As Amended by Senate Committee

[As Amended by House on Final Action]

Session of 1996

Substitute for HOUSE BILL No. 2756

By Committee on Public Health and Welfare

3-3

AN ACT concerning preschool children; relating to reporting of certain conditions of such children to the secretary of health and environment.

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

Section 1. The purpose of the reporting requirement of this section is to allow the collection of accurate information concerning preschool children under six years of age within the state who are at risk for, or who have, handicapping conditions. Every physician who has primary responsibility for treating such a child shall report the case to the secretary of health and environment on forms provided by the secretary. The report shall not identify the child or the parents or guardian of the child. The information may be used only as aggregate data for research and statistical purposes and to plan for services for such children.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

[Section 1. As used in this act:

[(a) "Handicap or chronic condition" is an organic disease, defect or condition which may *means a physical handicap or chronic disease which will* hinder the achievement of normal physical growth and development.

[(b) "Mental retardation" shall have the meaning as is ascribed to such term by K.S.A. 76-12b01 and amendments thereto.

[(c) "Physician" means a person licensed to practice medicine and surgery.

[(d) "Secretary" means the secretary of health and environment.

[Sec. 2. The secretary of health and environment shall supervise the reporting of conditions of preschool children who are under six years of age that are likely to lead to, or that indicate the existence of, *any medically diagnosed condition of a preschool child under six years of age that indicates* mental retardation or a handicap or chronic condition. Every *Except as otherwise provided in this section, every* primary care physician treating a child with such *who has primary responsibility for treating a child with such a diagnosed* condition shall report the case to the secretary of health and environment on forms provided by the secretary. *Permission to make such report shall be obtained from the child's parent or guardian prior to making the report. No report shall be made unless such permission has been granted by the child's parent or guardian.* The purpose of this reporting is to collect and compile complete and accurate information concerning the number of preschool children within the state who are at risk for, or who have, *have* handicapping or chronic conditions in order to plan for and make available services to these children and their families. This information will be used only as aggregate data for research and statistical purposes and shall not be used to identify a child without permission from that child's parent or guardian. Permission from the child's parent or guardian shall not be obtained at the time of the report but shall be obtained separately at or after the time the information is received by the department of health and environment. If the child's parent or guardian refuses to grant such permission, the secretary shall remove the report on the child from the other reports and provide for the destruction of such report.

[Sec. 3. Any physician who reports in good faith and without malice, or who in good faith and without malice fails to report, the information required to be reported under this act shall have immunity from any liability, civil or criminal, that might other-

wise be incurred or imposed in an action resulting from such report. Any such person shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

[Sec. 4. Information obtained by the secretary under this act is confidential and shall not be disclosed except as provided in this section. The secretary may disclose information obtained under this act: (a) Upon the consent, in writing, of the person who is the subject of the information, or if such person is under 18 years of age, by such person's parent or guardian; or (b) upon the request of an organization or individual conducting a scholarly investigation for legitimate research or data collection purposes, so long as such information is disclosed in a manner which will not reveal the identity of the persons who are the subject of the information or the identity of the physician reporting such information. The secretary may disclose information obtained under this act to officers and employees of the department of education who are designated by the state board of education to receive such information. Officers and employees of the department of education who receive such information shall be subject to the same duty of confidentiality as the secretary with respect to such information.

[~~Sec. 5. In addition to the provisions of section 3 the~~ *The* secretary shall remove the records of a child whose parent or guardian requests in writing such action.

[Sec. 6. Any person, association, firm, corporation, organization or other agency willfully or knowingly permitting or encouraging the disclosure of information obtained under this act and not otherwise authorized to be disclosed under this act shall be guilty of a class C misdemeanor.

[Sec. 7. Nothing in this act shall be construed or operate to empower or authorize the secretary to restrict in any manner the right of a physician to recommend a mode of treatment for mental retardation, handicaps or chronic conditions or to restrict in any manner an individual's right to select the mode of treatment of such individual's choice.

[Sec. 8. The secretary may adopt rules and regulations necessary to carry out the provisions of this act. The rules and regulations shall include, but shall not be limited to, the following: (a) Procedures for reporting under this act; (b) procedures for review and follow-up on the case records of a child; (c) procedures for the protection of the confidentiality of information obtained under this act; (d) *with appropriate medical consultation* an enumeration of handicapping or chronic conditions to be reported under this act; and (e) procedures for obtaining permission from parents or guardians *to make the report and* for use of information obtained in the report.

[Sec. 9. This act shall take effect and be in force from and after its publication in the statute book.]

1-8

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Testimony Regarding S.B. 264

I am appearing today in regards to the proposed legislation in Senate Bill No. 264.

The proposed changes would permit an applicant or recipient of medical assistance who enters an institution or begins receiving home-and community-based services to divide the aggregate resources and income of the applicant/recipient and his or her spouse into separate shares. Only the separate resources and income of the applicant/recipient would then be considered in determining his or her eligibility for medical assistance.

The Medicaid program is the primary source available for payment of long term care. Under current Medicaid regulations, the total resources and income of the applicant/recipient must be considered in determining his or her eligibility. In light of these regulations, the bill would help alleviate the financial burden faced by a number of married couples throughout the State when a member of that couple must enter a nursing home for long term care. It provides financial protection for the spouse who remains in the community, particularly in those instances in which the applicant/recipient owns most of the couple's resources and/or receives most of the income. The Department is supportive of the division of assets provisions in the bill. However, the Department is unable to support the division of income provisions primarily because those provisions violate federal Medicaid statutes and regulations.

It should first be noted that the bill carries a potentially significant fiscal impact. As noted on the attached fiscal impact statement, the total yearly impact could be as high as $2.2 million with half of that amount coming from the State General Fund. Based on the State's current budget crisis and the Department's own appropriations level, the bill could further aggravate current fiscal problems. If the bill is enacted in its present form, the Department would likely have no choice but to request additional funding.

In regards to the issue of dividing assets, Medicaid regulations require that both real and personal property, whether jointly or solely owned by the applicant/recipient, must be considered including land, checking and savings accounts, trust funds, and life insurance. While certain resources are excluded from consideration such as the home the spouse continues to live in and an automobile, by and large all assets are viewed as being available to meet the cost of nursing home care. If most of those assets are jointly owned between the spouses and/or are solely owned by applicant/recipient, the spouse at home is left unprotected and, in many instances, may be forced into impoverishment based on using all of the couple's resources to meet the cost of nursing home care. The bill helps to prevent this from occurring by allowing the resources to be apportioned between the two spouses.

Although the Department supports the division of assets provisions, there are several concerns which need to be addressed. First, federal reaction to such a change may be negative. Section 1917(c) of the Social Security Act permits states to deny eligibility to persons who dispose of their resources at less than fair market value. This provision is commonly known as the "transfer of

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attachment 2

resources" provision. Kansas has had a long standing policy based in statute for denying eligibility due to an inadequate transfer of resources. This policy is reflected in the State's Medicaid State Plan, the document by which the federal Health Care Financing Administration (HCFA), the agency responsible for administering the Medicaid program, reviews and audits our Medicaid eligibility policies. HCFA could reject a change to this policy via the State plan and therefore force the State into taking legal action to resolve the issue.

It is important to note that approximately six other states have similar provisions and no federal action has been taken against those states. However, as the bill allows an applicant/recipient to transfer substantial amounts of resources to his or her spouse without compensation and for the purpose of becoming eligible for Medicaid, there is still the potential for such action.

Secondly, there appears to be an inconsistency within the bill regarding the Department's recovery ability. On the one hand, the bill prohibits the Secretary from recovering medical assistance paid on behalf of the applicant/recipient from the resources of his or her spouse. On the other hand, the Secretary is permitted to file a lien on the property of the applicant/recipient and his or her spouse to recover medical assistance provided the recipient. This apparent inconsistency needs to be resolved and clarified.

Third, in regards to the lien provisions themselves, the Department is restricted in its ability to establish liens as specified in S.B. 264 based on current federal statute. Section 1917 of the Social Security Act limits the State's authority to establish a lien to recover medical assistance paid for institutional care only from real property and only upon the death of the individual or his or her spouse. Based on the specific criteria of this section, the bill will need to be revised to exclude the authority to establish liens on personal property.

Fourth, also in regards to the lien provisions, it is not clear as to when a lien can be established and when it can be foreclosed. Current language would seem to indicate that the lien could be established and foreclosed after the first month of medical assistance provided. Also no indication is given as to how the amount of the lien is to be established. If filed during the life of the recipient or his or her spouse, the amount would need to be adjusted on a monthly basis because of the increasing cumulative medical expenditures of the recipient. Further clarification on these issues is necessary.

In regards to the provisions for dividing income, as mentioned previously, the Department cannot support those provisions as the bill violates federal Medicaid statutes and regulations and, therefore, creates the potential for federal legal action based on noncompliance as well as the potential for fiscal sanctions. Specifically, the bill violates section 1902(a) (10) (C) (i) (III) of the Social Security Act which requires states to apply the same financial methodologies for determining Medicaid eligibility of the aged, blind, or disabled as are applied in the Supplemental Security Income (SSI) program. SSI regulations at 20 CFR 416 require that any income received by the individual be counted in determining eligibility.

The bill also violates section 1902(a) (17) (B) of the Act which requires states to take into account all of the income and resources available to the applicant or recipient. By the same token, Medicaid regulations at 42 CFR 435.725 and 435.726 specify that the individual's total income must be considered in determining his or her obligation for care.

The Medicaid regulations do permit the institutionalized individual to allocate a portion of his or her income to the spouse at home to help meet the spouse's maintenance needs. However, the amount which can be allocated is limited to the State's Medicaid income standard for one person which is currently $341/month. The bill would in essence allow the applicant/recipient to allocate up to $717/month of his or her income and thus exceeds the regulatory limit.

It should be noted that two states, California and Washington, have attempted in the past year to submit amendments implementing similar provisions in their Medicaid State Plans. The Health Care Financing Administration has rejected the amendments and both states are currently fighting the issue in federal court. No final decisions have been rendered at this time.

In addition to the major issues addressed above, the Department has several other technical comments related to the bill as a whole. First, the definition of what constitutes a "qualified applicant" or "qualified recipient" includes a person who "is under institutional care." An "institution" is defined as "an adult care home or a long-term care unit of a medical care facility." At issue is the person's projected length of stay in the institution. It is believed that the bill is intended to address the needs of persons who enter a medical facility for truly "long-term care." It is not believed to be intended, therefore, to benefit a person who may, for example, enter an adult care home to recuperate from major surgery and then return home a month or two later. The Department defines long term care as care provided to a person in a Medicaid approved institution which exceeds or is projected to exceed 3 months, including the month of admission. Persons whose care is of shorter duration are not considered under the Department's long term care methodologies. It is therefore recommended that consideration be given to replacing the "under institutionalized care" phrase in the applicant/recipient definition with the phrase "receiving long term care in a Medicaid approved institution."

Secondly, in item (1) of section 2 and item (a)(1) of section 3 reference is made to the consideration of the separate resources and income of the applicant/recipient beginning either in the month following the month in which the applicant/recipient becomes a qualified applicant or recipient or in the seventh month following the month he or she becomes a qualified applicant or recipient. These provisions were originally based on the Medicaid provisions contained in 42 CFR 435.723. The Medicaid provisions however are based off of the month the applicant or recipient actually entered the institution. Therefore, the wording in both of these items needs to be revised to require that the separate resources and income of the qualified applicant or recipient be considered in either the month following the month he or she entered the institution (or began receiving home and community based services) or the 7th month following that month.

The final comment also is in regards to item (a)(1) of section 3. At issue is the qualifier that the separate income of a qualified applicant or recipient will be considered in the month following the month the person becomes a qualified applicant or recipient "if the applicant or recipient and the applicant's or recipient's spouse do not share the same room or if the applicant's or recipient's spouse is not applying for or receiving medical assistance." The phrase regarding the applicant/recipient and spouse sharing the same room is not appropriate and should be deleted as it is not an issue if the applicant/recipient's spouse does not apply for or receive medical assistance.

In summary, the Department supports the division of assets proposal in S.B. 264 but opposes the division of income proposal because of federal statutory and regulatory constraints. In addition, the Department notes the potential high fiscal impact of the bill as well as a number of issues requiring clarification or technical revision.

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

February 20, 1987

POTENTIAL FISCAL IMPACT OF S.B. 264

As mentioned in the testimony, the projected total year fiscal impact of S.B. 264 is $2.2 million. Approximately half of this amount would be from the State General Fund. This is based on 1980 Census data for Kansas regarding the percentage of institutionalized persons who are married and the number of persons who would be advantaged by the bill based on their income and projected resources.

According to the 1980 Census data, of the 36,000 persons who are institutionalized, 4,992 are married or 14% of the total. The current adult care home population in Kansas is approximately 25,000 with 12,000 receiving Medicaid payment and 13,000 in private pay status. Thus, approximately 1,680 Medicaid clients (14% x 12,000) and 1,820 private pay clients (14% x 13,000) are presumed to have spouses at home. It is also presumed that most of the current private pay individuals will convert to Medicaid payment during the year.

In regards to the provisions of Section 2 on division of assets, the current Medicaid population would not be impacted as they already meet resource criteria. Thus, only the private pay clients with spouses at home (1,820) would be potentially affected by the legislation.

Census data shows that 8.5% of the total Kansas population have incomes in excess of $8,000/year. It is presumed that a majority of these individuals will have some countable resources and might therefore fall under the provisions of the bill. It is also presumed that persons who divide their resources in accordance with the bill will qualify for an additional 12 months of medical assistance beyond what they would receive under current policy. Based on these assumptions the fiscal impact for the asset division would be:

8.5% of 1,810 persons = 154 persons affected.

154 persons x $700/month projected average cost of care in an Intermediate Care Facility x 12 months = $1.29 million.

In regards to the provisions of Section 3 on division of income, both Medicaid and private pay clients would be impacted by the legislation. As mentioned in the testimony, Medicaid regulations currently permit institutionalized persons to allocate up to $341/month to the spouse at home. Thus, based on the bill's premise of equally dividing the couple's aggregate income, the couple could currently have up to $682/month of $8,183/year in aggregate income which could be equally divided under current law. The bill would essentially allow the amount of allocation to increase to $717/month ($8,600/year protected for spouse in bill). The couple could then have up to $1,4324/month or $17,208/year in total income which could be equally divided without exceeding this limit.

Census data shows that approximately 6% of the total Kansas population have yearly income in the range between $8,184 and $17,200. If the bill would result in an average of an additional $200/month in spousal allocation, then the impact would be as follows:

6% of 1,680 persons = 100
6% of 1,820 persons = 109
209 total persons affected

209 persons x $200/month x 12 months = $501,600

Census data also reflects the fact that 2.5% of the total Kansas population have incomes in excess of $17,200/year. Thus, under the bill's provisions, these persons could allocate an additional $376/month above and beyond current policy ($717/month - $341 current allowable allocation). The impact for this group would be as follows:

2.5% of 1,680 persons = 42
2.5% of 1,810 persons = 45
87 total persons affected

87 persons x $376/month x 12 months = $392,544

The fiscal impact for the income division is then $894,14 ($501,600 + $392,544).

The combination of fiscal impacts for both the asset and income provisions results in a total fiscal impact for the bill of $2.2 million ($1.29 million + $894,144) or $1.1 million SGF.

ATTACHMENT TO TESTIMONY ON S.B. 264 - EXEMPTED RESOURCES

Under current state and federal regulations, the following resources are not considered in determining medical eligibility for an aged, blind, or disabled person.

1. The home if used as the person's principal place of residence. If the person does not reside there, the home would still be exempt if he or she intends to return to it at sometime or if the person's spouse, dependent children, or dependent relative continue to live there.

   NOTE: The home includes the tract of land and contiguous tracts of land upon which the house or other improvements are located. There is no acreage limitation.

2. One automobile per family. Additional automobiles may be exempt if shown to be essential for employment for self-support, for medical treatment, or if specially equipped for use by a handicapped person.

3. Income producing real and personal property, other than cash assets, whose total equity does not exceed $6,000 and whose net annual return is at least 6% of equity. Equity in excess of $6,000 is considered nonexempt.

4. Life insurance not exceeding $1,500 face value for each family member. If in excess of $1,500, all cash surrender value must be considered.

5. Burial spaces, caskets, urns, and other burial repositories for each family member.

6. Revocable burial funds of up to $1,500 per person. Face value of any life insurance reduces the amount which can be exempted.

7. Personal effects and keepsakes. Also household equipment and furnishings in use.

8. A contract from the sale of real or personal property if the proceeds from the contract are considered as income.

9. Proceeds from the sale of a home if the proceeds are conserved for the purchase of a new home and are then expended or committed to be expended within 3 months of the sale.

A family may own nonexempt real or personal property with a value not in excess of $1,800 for 1 person or $2,700 for 2 or more persons.

TESTIMONY ON S.B. 264
BY LOIS JOHNSON, MCDONALD, KANSAS
FEBRUARY 19, 1987

Senate Public Health and Welfare Committee:

I support Bill 264

This bill covers all long term care illnesses, but I am here to tell you about one disease, Alzheimer. My husband, Tom, was stricken with this disease five years ago at the age of 49. Alzheimer disease is a very expensive disease. To get a diagnosis is a lengthy process sometimes taking as long as a year including a lot of testing that is not covered by any insurance. At age 49 most couples are just beginning to build a savings or a retirement fund. We still had two children in college, so our savings was soon depleted and we were borrowed to our maximum.

Alzheimer disease destroys the short term memory banks and slowly returns an adult into an infant, requiring total care. This disease lasts from 3 to 15 years with the last stages needing total nursing care at the expense of $1,500 to $2,000 a month. For the well spouse this disease seems like a tunnel with no light at the end. At this time in Kansas there is no financial help until a couple has spent their resources down to $1,700. For me this is very frightening, as I have a lot of years to make my living and care for a sick spouse.

This bill is a good bill and a bill I feel will help the middle income families and the elderly on social security with a small savings account. I do not feel this bill will cost the state any more in the long run than it will cost to keep two people on the welfare programs once their assets are all spent. I realize the budget is being cut at this time but we feel this is a short term problem, but the needs for a division of assets is a long term problem and one that every state is starting to realize.

I do not feel the people in the high asset level will choose to divide their assets and tie up the remainder of their assets with a fourth class lien as the bill requires. Once again I feel this is a bill for the population of Kansas that is not poor enough for aid, but also not wealthy enough to be able to survive the tremendous expenses of these diseases.

At this time lawyers across the state are advising their clients to divorce in order to divide their assets and have enough left to be able to live with dignity. Divorce is an added trauma to an already very sad situation. Kansas should have more to offer to the people that have always been the backbone to this state's economy.

When you vote on this bill, please do not think of the budget problems, but put yourself in my place. How long would your assets last at $2,000 a month expenses for a sick spouse? Which choice would you decide, divorce or poverty? This is not an easy choice and a choice that should not have to be made.

Thank you for your time.

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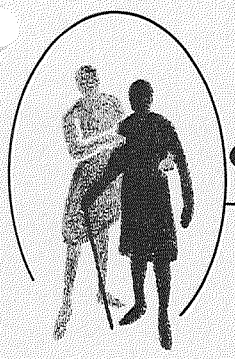

The Lorraine Center

The Lorraine Center • 656 South Chautauqua • Wichita, Kansas 67211 • (316) 687-4088

February 20, 1987

Senators: Thank you for giving me the opportunity to speak with you on an issue about which I care very deeply - Division of Assets.

My name is Jo Androes. I work at The Lorraine Center in Wichita. The Lorraine Center is a church sponsored, non-profit Adult Day Care facility, which serves disabled adults and frail elderly.

Many of the people we see at the Lorraine Center have some form of dementia, including a number who are victims of Alzheimer's disease.

I am a widow. When my husband died six years ago, he died of cancer. Our insurance company co-paid expensive prescriptions, and took care of the hospital bills. With cancer, a family may be emotionally devastated, but the survivors probably won't be left in total financial ruin.

Such is not the case when a family faces a long-term catastrophic illness such as Alzheimer's disease. Insurance companies exclude long-term care benefits to Alzheimer patients. Medicare is of no help to dementia victims, since there is little chance of their condition improving. Prescriptions frequently cost more than the family's total monthly income. There is simply no where a family can turn for help.

Most of these families face only one future - abject poverty, no matter how hard they may have worked all their lives. If they have scrimped and saved a little nest egg for security in their old age, they quickly learn their frugality is going to result in their being penalized, if a family member needs long-term care.

Let me tell you about one family we have worked with at The Lorraine Center. The husband has been in a mental decline for a number of years. His dementia is now both advanced and severe.

As is so typical, his wife has cared for him at home, until now her own health - both mental and physical - is nearly destroyed. She cannot leave him alone, even long enough to go to the grocery store, since he frequently wanders away.

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She has had to remove all the carpets in the house, since, in his confusion, her husband can't remember where the bathroom is, so he urinates beside the bed, in corners, in the hallway, and in the living room. The odor in the house is now unbearable.

Finally, a couple of weeks ago, her hands shaking, and unable to speak without crying, the wife left her husband at The Lorraine Center, and spent the day trying to find a nursing home where her husband could have full time care.

She quickly realized there was no way they could pay the cost of full time care, so she checked to see if there was some way of getting Medicaid to help.

She found there was not. The reason? They have a four-thousand dollar C.D. - saved for years - earmarked to cover their funeral and burial expenses when they die. That's about all they have now, after the years of the husband's illness - just enough to pay for their dying.

But that is enough to preclude any state assistance. So here we have an elderly couple. They've tried - and succeeded - in caring for themselves all these years. Until now.

The husband probably won't live much longer. The wife - the so-called "well spouse" - now in broken health herself - will probably have to go on welfare for the remaining time she has.

A Division of Assets bill might permit people like this to retain some shred of dignity, for whatever time they have left.

Senators, this couple and their tragedy is not an isolated case. It could happen to your next door neighbors, your parents, and eventually it could happen to you.

Is it really necessary that the well spouse be stripped of every last asset before they can receive any help? The possibility for finding a solution rests in your hands; surely something can be done.

Thank you.

Kansas Retired Teachers Association

Together We Can

1986-1987

February 19, 1987

To Members of the Senate Public Health and Welfare Committee:

My name is Basil Covey and I represent the Kansas Retired Teachers Association.

We support SB's ~~12~~ 264 ~~and 13~~ that divides assets or resources of spouses' caught in a long term illness situation.

There is statewide support for these bills. In KRTA district meetings held in Ford, Wichita, Manhattan, Iola, Ottawa and Salina retired teachers expressed a need for this legislation.

Several tragedies were heard in an interim study this summer. The record shows that a couple's assets are used up in about four months when one spouse has a long term illness.

Three states, California, Illinois and Colorado have division of asset legislation. They are in great detail and will not be given here.

Retired and elderly citizens should be allowed to handle their assets so in case of catastrophic illness of one spouse both will not be on Medicaid.

We urge your support for SB's 264 ~~12 and 13~~.

Sincerely,

Basil Covey
KRTA

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Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

Office Phone
913/233-7483

To: Senate Committee on Public Health and Welfare

Re: SB 264

I would like to discuss a problem we find in SB 264. There is no difficulty with the first three sections which allow couples to divide assets and income.

Section 4 (page 7), which is present law providing criminal penalties for nonsupport of a child or spouse, can be troublesome for those who rely on spiritual means for healing in lieu of medical care and treatment.

The legislatures of Kansas and most other states have been generous throughout the years in providing for those who, as a result of deeply held religious conviction, have chosen to rely on spiritual means for treatment and healing. Christian Scientists have been doing this for more than one hundred years. Some Kansas families have relied on this method of healing alone for four or five generations.

K.S.A. 21-3605, which makes nonsupport of a child or spouse a class E felony, could subject a parent or spouse to criminal charges for failure to use financial resources or income to provide medical care. Amendments to the law in this bill (lines 0336-0348) clearly raise the issue of providing medical support.

It is requested that K.S.A. 21-3605 be amended to make clear that provision of spiritual treatment in lieu of medical care and treatment will not be considered to be nonsupport.

One possible method of amendment would be to insert after lines 0250 and 0302 the following words, as appropriate:

> "Providing treatment by spiritual means alone through prayer, in lieu of medical care or treatment, for the treatment or cure of disease or remedial care of such individual's (child)(spouse) shall not constitute nonsupport."

An amendment of this nature should prevent prosecution of those conscientious citizens who choose to rely on spiritual treatment.

For those concerned that children's welfare might be affected by this amendment, it should be pointed out that a court still could order medical treatment for a child under the provisions of the Kansas code for care of children (K.S.A. 38-1502, 38-1513).

If the suggested wording is not found suitable, I will gladly work with the committee and staff to find a satisfactory solution to this problem.

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Keith R Landis
Committee on Publication for Kansas

KANSAS

DATE: 2-19-87

TO: Senate Public Health and Welfare Committee

FROM: Gail J. Hamilton, Kansas National Organization for Women

RE: SB 264, Division of Assets

Thank you Mr. Chairman, members of the Committee.

Kansas National Organization for Women has included spousal impoverishment or spousal division of assets on its 1987 Legislative Agenda. We support legislation that addresses this issue.

There are two major reasons why we support legislation as contained in SB 264.

The first is that people aged 65 and over are the fastest growing segment of the population. By the year 2030 they could make up one fourth of the total U. S. population. According to the House Select Committee on Aging, about 86% of the elderly suffer from at least one chronic health condition and more than half are constrained by chronic illness. Health problems of the elderly are more likely to require the long-term, chronic care not covered by Medicare. It also appears likely that a substantial percentage of the elderly run the risk of impoverishment under Medicaid either as an applicant or a spouse, at least under current state and federal regulations.

A second key reason for NOW's concern is that spousal impoverishment disproportionately affects women, who make up 80% of surviving spouses. Women not only live longer than men, but often receive smaller pensions from careers interupted for childrearing or no pensions of their own due to a lifetime of unpaid work in the

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home or in low-paying service sector jobs. Traditionally, they have been dependent upon more valuable pensions and other financial resources listed in their husband's names.

Current federal and state regulations have been short-sighted in their approach to the serious issue of health care for the elderly. I applaud your efforts to correct that situation in Kansas, and offer our support to those who are finalizing the technicalities of this bill for final passage out of committee.

Published in The Journal of the Kansas Bar Association, Vol. 55, No. 7, September, 1986.

DIVISION OF ASSETS: A STATUS REPORT

The Interim Committee on the Judiciary has been wrestling this summer with the question of the appropriate financial responsibility of one spouse for the medical needs of the other. Perhaps wrestling is not a strong enough word when the subject involves Title XIX of the Social Security Act and the Medicaid program, which Chief Justice Burger has called "a morass of bureaucratic complexity," and Judge Friendly has described as "a Byzantine construction making it almost unintelligible to the uninitiated." Apparently, the Kansas House was not intimidated. House Bill 3063 was introduced in the 1986 session by the Committee on Public Health and Welfare and referred to the Interim Committee for study. That bill would amend K.S.A. 39-709 and K.S.A. 39-719a and substitute a new section that provides a husband and wife may separate their income and resources into equal shares for purposes of determining eligibility for medical assistance under the Medicaid program. The bill places new limits on the subrogation rights the Secretary of Social and Rehabilitation Services now has against a spouse when medical assistance has been paid for the other spouse. There would be no subrogation rights to income at or below the national median family income. After a separation of resources, the resources of the well spouse would not be subject to subrogation.

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The proposed legislation is a result of the growing concern for the plight of a well spouse when a sick spouse is placed in a nursing home, brought into focus by the Alzheimer's and Related Disorders Chapters in Kansas and the Governor's Task Force on Alzheimer's. Long-term care insurance, until very recently, has not been available at any price and the Social Security Medicare program covers only skilled nursing home care for short periods of time. Yet, Medicare and private insurance pay only about three percent of the total nursing home care costs in the United States. The only government program that is available to assist in the payment of long-term care is Medicaid. Medicaid is a joint federal and state program which pays for the medical and care costs of the medically needy under Title XIX of the Social Security Act. In Kansas, Medicaid is operated by Social and Rehabilitation Services following the regulations of the Health Care Financing Administration of the U. S. Department of Health and Human Services. In Kansas, there are approximately 19,000 persons in nursing homes, with over 10,000 in the Medicaid program. Currently, Kansas and the federal government each spend approximately 48 million dollars paying the nursing home bills of the needy.

In determining the eligibility for Medicaid where only the one spouse applies for the program, federal and state regulations provide that the resources and income of the well spouse are "deemed" to be available to the sick spouse as long as they are living together. When they are separated because of the need of

institutionalization for the sick spouse, the deeming rule applies only during the first month of institutionalization.[1] After the first month of institutionalization the following eligibility rules apply:

RESOURCE LIMITS:[2]

1. The home, household goods, a car, and $1,700 are protected resources. All other resources belonging to the sick spouse must be spent down to the $1,700 level prior to eligibility.

2. Jointly-owned personal property is deemed to be an available resource to the sick spouse and must be spent down in full.

3. Jointly-owned real property is divided equally and the sick spouse's half must be spent down.

INCOME LIMITS:[3]

Kansas follows the "Name on the Instrument Rule" in regard to income.

1. The first $25 per month of income belonging to the sick spouse is protected income. All other income belonging to the sick spouse is available for payment of the costs of care.

2. The income of the well spouse is not counted as available for purposes of eligibility. Should the well spouse's

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[1] 42 C.F.R. § 435.723 (d)

[2] K.A.R. 1983 30-6-106 to 30-6-109.

[3] K.A.R. 1983 30-6-110 to 30-6-113.

income be less than $341 per month, income from the sick spouse up to that level can be diverted to the well spouse.

The eligibility requirements in Kansas, however, are only part of the story as the Kansas statutes now provide that the Secretary of Social and Rehabilitative Services is subrogated for all monies paid out under the Medicaid program to those who are bound by law to support that person, which simply means that the Secretary of SRS requires that the well spouse reimburse the state from non-protected resources and income for all payments under Medicaid until the well spouse has resources of $1,700 or less and income of $341 per month, thus reducing both spouses to the poverty level.[4]

Other states have attempted to prevent the impoverishment of the well spouse in a variety of ways. New York has seen a number of successful support suits brought by the well spouse against the sick spouse and where the court divided the couple's income.[5]

This year, the California legislature passed a bill that permits an agreement between spouses equally dividing their property and, if there has not been an agreement, the resources are regarded as equally divided as of the date of the institutionalization of one of the spouses.[6] This state's Medicaid

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[4] K.S.A. 39-719a.

[5] Department of Social Services on behalf of Joseph M., Petitioners v. Barbara M., Respondent. Family Court, Dutchess Co., 123 Misc.2d 523. Also see Brill v Perales 82-CV-1271 (N.D.N.Y. 1985)

[6] Cal. Welf. and Inst. Code 14006.2 (c) 1986

plan, incorporating the new statute, was not approved by the Secretary of Health and Human Services and the matter is currently pending in the United States Court of Appeals for the Ninth Circuit.

The Supreme Court of Washington held in Purser v. Rahm that

> Washington community property law was not preempted for purposes of determining ownership of income in computing eligibility for medicaid benefits for nursing home costs by federal medicaid statutes or regulations, and thus Washington Department of Social and Health Services could be required to apply community property laws in computing eligibility.[7]

Subsequently the Washington Legislature enacted Senate Bill No. 4659 which permits agreements between spouses transferring resources and the income produced by the transferred resources. The bill further provides that if the community income received in the name of the nonapplicant spouse exceeds the community income received in the name of the applicant spouse, the applicant's interest in that excess shall be considered unavailable to the applicant. The Washington Medicaid plan incorporating that statute has also been disapproved and is now pending in the United States Court of Appeals for the Ninth Circuit.[8]

Thus, the newly-written statutes in these and other states attempting also to wrestle with the issue are meeting opposition from the federal government. Kansas is not alone.

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[7] 702 P.2d 1196 (Wash. 1985)

[8] Docket No. 86-7188.

After hearings on the Kansas Bill 3063, the Interim Committee referred it to a sub-committee for further study. The sub-committee reported four options for the consideration of the full committee.

Option one: All joint tenancy property is to be treated on a pro rata basis triggered by the institutionalization or home-based care service of one spouse.

Option two: In addition to option one, a transfer of $25,000 total assets would be allowed with a lien against the estate upon the death of the well spouse.

Option three: A division of assets would be permitted with a fourth class claim against the estate. Subrogation against the well spouse limited to income in excess of $8,600 per year.

Option four: An income division would be permitted up to a maximum of $8,600 per year.

The full committee met on August 28, 1986 to consider the report of the sub-committee. At that meeting, there seemed to be a general consensus that a bill dealing with a division of assets and income should be recommended by the Interim Committee, but it was less clear what form a bill might take. The Interim Committee directed that three bills be drafted incorporating all four options, which will again be considered at their October meeting. It appears that the next session of the legislature has the opportunity to provide some method of dividing assets between spouses short of divorce.

Donald F. Rowland, J.D., Washburn University School of Law '59, has been Professor of Law at Washburn University since 1970 and recently served on the Governor's Task Force on Alzheimer's and Related Disorders.

Alzheimer's Disease and Related Disorders Association
TOPEKA CHAPTER

P.O. BOX 1427
TOPEKA, KS 66601

Testimony in support of SB 264

Wanda Blaser, RN, MSN
President, Alzheimers Disease and Related Disorders Association
Member, Kansas State Task Force on Alzheimers Disease

From my work as a support group leader and at the state task force hearings on Alzheimers Disease I have heard the priority family concerns as need for some type of financial assistance and acceptable insurance coverage. Long term care expenses are frequently devestating for persons/families requiring such care. Medicare is not designed to cover long term care and private insurance does little if anything to fill this gap. Without the benefit of private insurance for the long term care required for Alzheimers Disease, payments for these services have come to represent enormous out-of-pocket expense. Thus, as a result of funding their own extended care needs, many people become candidates for Medicaid.

Our Alzheimers families are in this category. They have worked hard to support themselves and through no ones fault are now forced to deal with a debilitating disease lasting an average of 8-10 years. I have seen spouses fear living in poverty, but realizing that is what they will have to do in order to receive the needed care for the ill spouse. We do not want to support a system that forces a married couple to choose between poverty or divorce to receive the care needed for a loved one.

I urge you to support SB 264 and provide the spouse of the Alzheimer's patient opportunity to receive needed care for his loved one while continuing to care for himself.

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