Approved 2-20-89
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on February 16, 1989 in room 423-S of the Capitol.

All members were present except:

Representatives Flottman, Weimer, Shallenburger, all excused.

Committee staff present:

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

Conferees appearing before the committee:

Emalene Correll, Research
Norman Furse, Revisor
Representative Jessie Branson

Chair called meeting to order, drawing attention to agenda this date. He introduced members in the audience who are members of the Commission on Services for Medically Indigent and Homeless, Mr. Ralph Turner, and Mr. Jeff Ellis. He then invited Ms. Correll to begin her comments.

Ms. Correll gave a detailed report on Commission on Services for the Medically Indigent and Homeless, and the action taken over the period of time it has been meeting. She then gave their recommendations. A copy of the full report given by Ms. Correll will be recorded as an Attachment to these committee minutes when it is received.

Chair thanked persons from the Coalition on Aging who were in attendance this date for giving us some of their time. He apoligized for lack of seating for some.

Mr. Furse explained in detail the proposed legislation that has been recommended by the Commission on Services for the Medically Indigent and Homeless. (See Attachment No.1), for full details. May it be noted, the request in Attachment No. 1, the request under (1.) has been requested of the Senate Public Health and Welfare Committee this date. Numbers (2., 3., 4., and 5) are requested of this House Public Health and Welfare Committee. The final item in Attachment No.1, in regard to the Oregon Insurance Pool is still under advisement and will be further studied by the Commission. At the conclusion of Mr. Furses' comments, Chair asked wishes of members in regard to legislative requests.

Rep. Foster moved we introduce all this requested legislation and have it returned to this committee, seconded by Rep. Amos. Some observations were stated, but no discussion. Vote taken, motion carried.

Rep. Branson then gave a wrap-up report on the Commission's findings and recommendations. See (Attachment No.2) for details in request for Resolution to address need for more nurse practitioners to staff local health departments. See (Attachment No.3), for details explaining tasks to be followed by Office of Rural Health, in Resolution to be drawn. See Attachment No.4) for details in recommendation of phasing in additional children, pregnant women and infants into the Medicaid program. See Attachment No.5) for details of Bill request to expand the length of time for existence of the Commission on Services for Medically Indigent and Homeless.

At the conclusion of Rep. Branson's remarks, she urged for support of the recommendations of the Commission.

Rep. Wiard moved to adopt legislation to request extension of said Commission to December 31, 1989, seconded by Rep. Reinert. Discussion ensued, perhaps that will not be enough time for remaining concerns to be studied, and a later date of June 30, 1990 seemed more practical. Rep. Wiard and Rep. Reinert both withdrew their motions.

Discussion continued. Rep. Scott then made a motion to amend legislation to extend the time of the Commission on Medically Indigent and Homeless to the date of June 30, 1990, seconded by Rep. Sader. No discussion, Vote taken, motion carried.

Rep. Wiard then made a motion to introduce the bill as amended, seconded by Rep. Reinert. No discussion. Vote taken, motion carried.

Chair noted all bills requested this date will be introduced and the request will be made to have them returned to this committee.

Rep. Green made a motion to have a bill introduced that would deal with the problem of a child born from an abortion, said child is considered in need of care. (This is similar to a bill in Senate). Motion seconded by Rep. Reinert. No discussion. Vote taken, motion carried.

Chair thanked all in attendance for their patience.

Meeting adjourned, 2:55 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date 2-16-89

Name	Organization	Address
Bob Corkins	Ks. Hospital Assn.	Topeka
[illegible]	KDHE	Topeka
Jess Bales	Ks. Assn of Prof Psychologists	Topeka
JOHN A HOLMGREN	Catholic Health Assn	"
Jeff Rockett	St. Francis - Wichita	Topeka
KEITH R LONDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
Sue Ellen Weber	KS Dept on Aging	"
Charles Kavanaugh, M.D.	KDHE	Topeka
Allyn Morgan	SRS	"
Barbara Frank	AAT	Overland Park
Mary Frank	Shawnee Mission Medical Center - Volunteer	Overland Park, Ks
Chris Wheeler	KMS	Topeka
Marcia McClanahan	MIDWAY KANSAS CHAPTER AMERICAN RED CROSS	WICHITA
Bernadine Cooper	CCA	Lawrence
Kate Klassen	SRS	Topeka
Linda Tarbox	Lawrence - Dog Co Health	Lawrence
E J Sims		O. P.
Paul Johnson	PACK	Topeka
Ralph Thurston	COMM-MED IND-HANDICAPS	LAWRENCE
Sandra Strand	Douglas Co. Senior Services	Lawrence
Bob Hubert	" " 745 Vermont	"
Jeffrey O. Ellis	Cmsn Saves Indigent	Leawood
Kathryn Schmitt	Senior Citizen	Ft. Scott

Name	ORGANIZATION	ADDRESS
Lois Erie	Bourbon County Senior Citizens	1523 Beech Fort Scott
Clara Stevens	Mid America Council on Aging	132 S Main Chanute
Leona Jones	Silver Hair Leg	1443 S Main Altamont
Ruth Lyddane	Senior Citizen - Lyon Co.	Admire Ks.
Earl Lyddane	Senior Citizen - Lyon Co.	Admire
Vera Morris	Silver Haired Legislature	527 W 5th, Ft Scott
Elaine Emert	SHL	47, SW 66 St PV 66208
Marjorie Rees		2511 W 66 Terr SM. Ks 66208
Louise Ostlund	Area wide Council of Leavenworth Wyandotte AOA	1203½ 10th Ave, Leav 66048
Nathan Hanks	Spearville, Ford Co SHL	

SUMMARY OF APPROVED LEGISLATION -- COSFMIAH

1. Legislation establishing a council on indigent health care. This agency would be a clearing house for information on this subject and would provide ongoing policy development, planning and implementation of programs to assist the medically indigent. The agency will be within the governor's office. The agency would have authority to select a coordinator. In addition it would provide oversight of state and local indigent health care problems. The council will be composed of the maximum of 11 members and may appoint advisory groups to assist the council.

2. Legislation which would grant to the Secretary of Social and Rehabilitation Services general authority to allow MediKan by-ins. This would be allowed to individuals who have incomes under the federal poverty levels. It would be administered as part of the state medical assistance program. There would be a sliding fee scale based upon the ability to pay. Persons eligible could have any income of not more than 200% of the federal poverty level. If the employer is offering health insurance, the employee would not be eligible for this program.

3. Amendments to statutes authorizing the Secretary of Health and Environment and the Secretary of Social and Rehabilitation Services to provide outreach services to the citizens of the state.

4. Legislation requiring the preparation by each county of a survey of the provision of basic health services for medically indigent residents within the county.

5. Legislation concerning scholarships for certain students of the healing arts providing services for medically indigent persons which would forgive student obligations based on such service.

■ A bill similar to the Oregon insurance pool for small employers which provides incentives to small employers to offer health insurance to their employees. (Draft Bill not yet approved).

PA & W
attm # 1
2-16-9

STATE OF KANSAS

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER: PUBLIC HEALTH AND WELFARE
VICE CHAIRMAN: COMMISSION ON ACCESS TO SERVICES FOR THE MEDICALLY INDIGENT AND THE HOMELESS
MEMBER: EDUCATION
TAXATION
STATE ADVISORY COMMISSION ON SPECIAL EDUCATION

February 8, 1989

Representative James Lowther, Chair
Representative Bob Mead, Member
Representative Bill Wisdom, Member
Sub-committee, KDHE Budget
House Appropriations Committee

From: Representative Jessie Branson, Vice Chair
Commission on Access to Services for the Medically Indigent

SS512

During the 1987 Session, legislation was passed to establish the Kansas Commission on Access to Services for the Medically Indigent and Homeless. The Commission, composed of four legislators and five appointees of the Governor, held numerous meetings in Topeka and at various sites around the state during the past 14 months.

The report of the Commission, which is momentarily due to be submitted to the Governor and to members of the Legislature, carries strong recommendations concerning local health departments and district health offices.

The incidence of medical indigence nationally as well as in Kansas has been identified by numerous studies. Surveys on Kansas generally reveal the same findings as those done nationally -- that around 15% of the population is without health care coverage.

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However, it is important to note that a contributing factor in Kansas is the high proportion of small employers who may not, or can not, provide insurance for a variety of reasons. Over 50% of the medically indigent are employed -- often referred to as "the working poor".

Additionally, Kansas has a relatively large rural population which is finding access to health care increasingly difficult.

One of the consequences of this dilemma is that local health departments are hit with an increasing demand for primary care services. Testimony the Commission received from local health department nurses always expressed deep frustration and concern regarding the increasing numbers of families who are seeking help and the fact that local health departments do not now have the capability of providing primary care (children with earaches, fever, lacerations, etc., were most frequently cited along with greater demands for pre-natal and peri-natal care). Often we were told, "We just don't know what to do with 'these people'!"

The Commission recommends that the services of local health departments be expanded and that, where feasible, the local public health agency's role be expanded to include the provision of primary health services.

In addition, the Commission recommends that the staff of the district offices of the Department of Health and Environment be expanded by the addition of nurses who are experienced in the field of public health and who have received training in the delivery of basic health services.

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(To address the need for more nurse practicioners to staff local health departments as well as other programs, the Commission is introducing a House Concurrent Resolution in the '89 Session urging the schools of nursing education in Kansas to act expeditiously in developing nurse practioner training programs).

I bring this matter to the attention of the Sub-Committee to alert you to the findings of the Commission and to urge the Committee to do whatever might be attainable to provide as much support as is possible for our local health departments. It is obvious that formula funding must be enhanced in order for local health departments to be staffed to meet this acute need.

Thank you very much for your attention.

cc: Senator Roy Ehrlich, Chair
Commission on Access to Services for
the Medically Indigent

Representative Belle Borum, Senator Gene Anderson,
Members of the Commission

Governor Mike Hayden

attm #2
2-16-9

KDHE OFFICE OF RURAL HEALTH

Presentation by Secretary of Health and Environment
Stanley C. Grant, Ph.D.

January 17, 1989

The future of rural communities has been at the forefront of discussion nationally and here in Kansas. The Task Force on the Future of Rural Communities commissioned by Governor Hayden has made recommendations creating a comprehensive, cohesive policy to assist rural areas. It states that rural citizens must have access to essential services. These services should include adequate health care, transportation, water, financial institutions, and basic goods and services. My task this morning is to focus on adequate health care in rural Kansas.

Today's rural America has six characteristics which are particularly striking. First, in the aggregate, the economic structure of rural America is strikingly similar to the economic structure of metro America. Second, the diversity among the nation's rural counties is phenomenal, and certainly dwarfs the diversity among metro counties. Third, rural America's diversity manifests itself in highly specialized economic activity within any particular local area. Fourth, the economy of rural America is integrated into, and very interdependent with, the larger national (and international) economy. Fifth, this economic integration, when coupled with the existence of specialized local economies, means that the rural economy is terribly fragile and extremely vulnerable to the effects of outside forces. Sixth, the previous five characteristics of rural America are relatively new developments. In addition to these economic parameters, there are also certain demographic characteristics of rural Kansas that are necessary to keep in mind: 1) there are fewer minorities; 2) a larger percentage of the population is elderly; 3) the populace is generally less well educated; 4) there is more substandard housing; 5) poverty is often hidden; 6) there is underemployment rather than unemployment. There are also important strengths in rural Kansas: 1) a strong sense of belonging; 2) an established interdependence; 3) access to local government; and 4) a strong work ethic.

With this general background, a statement of how we arrived at the current crossroads in rural health care delivery is in order. The decade of the 1970s was a period of extensive governmental effort, at the federal and state level, to address poor distribution of health care providers and services in rural areas. The focus of this effort was to try to replicate the urban delivery model and was funded primarily on a cost reimbursement basis. In the decade of the 1980s, funding was reduced for many programs and full cost reimbursement was replaced by prospective payment systems which have worked to the detriment of rural health services. In addition, shortages of physicians and professional support staff in rural areas threatens the quality and availability of health care delivery. We are now approaching the 1990s with the realization that trying to duplicate the urban delivery model will not assure access to services in rural Kansas. The Governor's Task Force calls for a speedy resolution of the medical malpractice crisis and for a readjustment of the Medicare reimbursement rates to more equitably compensate rural hospitals. Both of these are important steps to assure adequate rural health care and must have bipartisan support. Kansas cannot provide rural health care without doctors in rural communities. In addition, the report calls for reorganization of the rural health care delivery system, but does not recommend what type of reorganization would be beneficial to rural health.

I would like to sketch out the basics of what I believe to be an effective rural health care delivery system, highlight some programs nationally that are being tested and review those public health efforts currently underway in Kansas and the role public health will play in rural health in the future. One adage

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states, "If you don't have a hospital, you don't have a town." The notion that a hospital is health care is a perception that will need to change throughout our state but most quickly in rural Kansas. Acute care is but one aspect of an effective health care system. Today's high technology makes it economically unfeasible to have a modern medical center in every community. I would propose that the adage needs to be, "If you don't have a coordinated Continuum of Care, you don't have town." An effective Continuum of Care must comprise the following components:

Emergency Medical Services
Complete Public Health Services
Primary Care Services
Good Linkage to a Medical Center
Complete Long Term Care Services
Home Health Services
Community Mental Health Services
Alcohol and Drug Abuse Services
Sound Social Services

A cost effective Continuum of Care requires a service population base which is larger than most single rural Kansas counties. Developing cooperative consortia of multi-county arrangements will be essential to assure availability of quality care. These consortia will require new working relationships between the public and private sector. The primary care physician continues to be the backbone of quality rural health delivery. Expanded use of midlevel health care professionals operating under the supervision of a primary care physician will increase availability of care. In rural areas throughout Kansas, public health is providing high quality preventive services and in many instances they are doing home care which is the essential link needed for complete long term care services. Immunizations, Healthy Start, Early Periodic Screening & Diagnostic Treatment, School Health, Well Child Assessments, sexually transmitted and communicable disease monitoring are all a part of the essential preventive health services provided by public health. In addition, the Women, Infant and Children (WIC) program, Life, Interest and Vigor Entering Later Years (LIVELY), and home health play a vital role in rural communities. In many rural communities, the Mothers and Infants (M&I) Program is filling the void for comprehensive prenatal services.

Nationally, there have been three major efforts to reorganize rural health. First, and only as a very limited demonstration in frontier areas, a medical assistance facility is being piloted. It is a facility staffed by midlevel health professionals to provide low intensity care for up to 96 hours. They are being piloted in two locations in Montana. Their effectiveness for Kansas may be questionable. Secondly, governments (both federal and state) have developed transition grant programs to provide seed money for local groups to do planning and reorganizing necessary to provide effective services. Many of these efforts have been focused on hospital consolidations and alliances for cost sharing arrangements. A third approach has been the involvement of private foundations which have focused on rural health care. They have provided seed money for regional arrangements which create cost effective and accessible rural delivery of health services. The common element of successful transition efforts has been the requirement for grassroots participation. I spoke at the beginning about the diversity of rural Kansas. There is not a single strategy for all areas. The outline of what is essential and what constitutes adequate quality is the same, but how it will be organized and who will deliver the pieces needs to be determined at the local level, not dictated by the State. At the Kansas Department of Health and Environment, we are defining the continuum of care; working with local health departments to determine areas where essential services are inadequate; focusing on the importance of integrating the public and private sectors in innovative delivery models; and seeking adequate funding for rural health departments (especially if they are trying to integrate services to create a most cost effective model). We are trying to keep uppermost in mind that any effective strategy must have the involvement of the local community.

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In order for KDHE to provide leadership and assistance on rural health care issues, it will be necessary for us to organizationally restructure so we can draw from our own, as well as other, resources. There is existing expertise and talent within our agency to address these issues, and we have a strong motivation to do so.

We will establish, within KDHE, an Office of Rural Health, consisting of one professional and one clerical person, to support a team of staff from various bureaus which will spend a portion of their time on rural health issues. Policy issues and health care proposals will be developed by this team and submitted to me for review/concurrence. This operation will be practical and realistic, and will not engage in the type of planning which just winds up on some bookshelf. I recognize that within the Division of Health, there is major involvement, crossing bureau lines, in rural health care delivery, including maternal and child care, nutrition programs, wellness activity and many others. Hence the need to involve a wide range of staff.

The following are examples of tasks to be carried out by the Office of Rural Health:

* Focal point for KDHE attention to a wide range of rural health needs and programs.

* Health assessment activities

    * Health status indicators

    * Health personpower analysis - specialists, physicians, nurses, nurse practitioners, aides, dietitians, sanitarians, and others.

* Review and analyze current efforts in health care in Kansas.

* Research approaches and models for health care delivery in other states--determine what ideas may be useful to Kansas. Avoid re-invention of the wheel.

* Define an appropriate range and continuum of health services for a specific rural community or region.

* Explore financial mechanisms to enhance delivery of care:

    *Work closely with private health insurers and public health insurers (e.g. Medicaid) to provide incentives for providers in rural areas, especially to increase coverage for primary care and preventive services.

    *Work closely with the Federal Department of Health and Human Services in exploring federal funding and program assistance such as "community health center" grants and National Health Services Corps placements.

    *Seek governmental and private grant funds as seed money for innovative demonstration projects.

* Explore an expanded role for local health departments in rural health care delivery.

* Develop a public participation mechanism at the local level to help determine appropriate activities by the state in local health care.

* Work closely with the Kansas Medical Society, Kansas Hospital Association, medical teaching institutions in the state and other organizations as well as the Governor and the Legislature to develop health delivery policy and models for Kansas.

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* Explore alternative health care delivery mechanisms for enhancing rural health care delivery, such as television, computers, telephones and telenet systems.

* Encourage cooperative public/private ventures for health care delivery.

* Assist in the development of health care networks which emphasize ambulatory care, home care and preventive services.
* Serve as a coordinator and clearinghouse for the state's efforts in rural health care delivery.

* Assist in developing a central program for enhanced recruiting of physicians and nurses for rural Kansas.

* Explore appropriate use of midlevel practitioners (e.g. nurse practitioners) in rural settings for our state.

And finally--anything else appropriate to provide better access and better quality rural health care to our citizens, and to assure that all of our citizens can get necessary health care.

Attm 3
2-16-94

STATE OF KANSAS

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MEMBER: EDUCATION
TAXATION
STATE ADVISORY COMMISSION ON SPECIAL EDUCATION

February 15, 1989

Representative Duane Goossen, Chair
Representative Jo Ann Pottorff, Member
Representative Jack Shriver, Member
Sub-committee, SRS Budget
House Appropriations Committee

From: Representative Jessie Branson, Vice Chair
Commission on Access to Services for the Medically Indigent

Jessie

Following the recommendations of a 1986 Interim Committee on Public Health and Welfare, legislation was passed during the 1987 Session to establish the Kansas Commission on Access to Services for the Medically Indigent and Homeless. The Commission, composed of four legislators and five appointees of the Governor, held numerous meetings in Topeka and at various sites around the state during the past 14 months.

The report of the Commission, which is now being printed and is due to be submitted to the Governor and to members of the Legislature, carries strong recommendations concerning expansion of the Medicaid program for pregnant women and children.

The incidence of medical indigence nationally as well as in Kansas has been identified by numerous studies. Surveys on Kansas generally reveal the same findings as those done nationally -- that around 15% of the population, or approximately 380,000 Kansans, is without health care coverage.

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It is important to note that a contributing factor in Kansas is the high proportion of small employers who may not, or can not, provide insurance for a variety of reasons. About 50% of the medically indigent are employed and often referred to as "the working poor".

One of the consequences of this dilemma is that providers of health care, including hospitals, local health departments, clinics for the medically indigent and physicians are hit with an increasing demand for health services by the medically poor.

Typically, such persons have not received preventive or basic health care and present themselves with an acute illness or accident. (Children with severe earaches or high fevers showing up at emergency rooms were frequently cited as were women who, having had little or no prenatal care, appear at the hospital door in labor).

We received a great deal of testimony to this effect, and when asked by the Commission where they (the providers) would place their priority in public assistance for indigent families, the answer was always the same -- "for the children, and on prenatal and peri-natal care."

The Commission applauds members of the 1988 Legislature and the Governor in adding pregnant women and children up to two years in families with incomes up to 100% of the federal poverty level to the Medicaid program. This action, in part, implements the Commission's recommendation during the '88 Session -- the Commission recommended including children up to five years.

I am informed by SRS that this expansion is successful and that there are now, at any given time, a total of 1400 additional women/children enrolled.

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The Commission continues to believe that prenatal care, infant care and preventive and primary care for children are a good investment for Kansas because they minimize the expense to taxpayers of low birth weight babies, and of long-term handicapping conditions in children and adults.

RECOMMENDATION

The Commission strongly recommends phasing in additional children to the Medicaid program, and that expansion be extended to children at 100% of the poverty level to age six for FY '90, to age seven for FY '91, to age eight by 'FY 92.

The Commission also strongly supports expansion for pregnant women and infants to 185% of the poverty level.

CAN BE HEALTHY (formerly EPSDT)

The Commission emphasizes that a significant benefit occurs from Medicaid expansion to children, in that these additional children are then eligible for CAN BE HEALTHY, which the Commission believes is a most valuable program. CAN BE HEALTHY provides the opportunity for examinations and screening at appropriate periodic intervals, which in turn opens up avenues for prevention, detection and treatment of various diseases and handicapping conditions.

Examples of such diseases and conditions would be anemia (including sickle cell), deafness, scoliosis (curvature of the spine), early diabetes, kidney disease, poor vision, speech defects. Certain indicators can also be detected, determining how well a child may get along scholastically or socially -- picking up on any conditions which would interfere with his/her education; providing treatment, referral.

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CAN BE HEALTHY gives children from low income families the chance to be healthier and more able to compete with children whose families can afford adequate health care early.

* * * * * * *

I bring this matter of Medicaid expansion for expectant mothers and children to the attention of the Sub-committe to inform you of the recommendations of the Commission, and to urge the Sub-committee to do whatever is attainable to provide as much help as is possible for medically poor families -- especially the children!

Thank you very much for your time and consideration.

cc: Senator Roy Ehrlich, Chair
Commission on Access to Services
for the Medically Indigent

Representative Belle Borum, Senator Gene Anderson
Members of the Commission

Secretary Winston Barton, SRS

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_____ BILL NO. ____

By

AN ACT concerning the commission on access to services for the medically indigent and the homeless; amending K.S.A. 1988 Supp. 74-8501 and 74-8505 and repealing the existing sections.

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

Section 1. K.S.A. 1988 Supp. 74-8501 is hereby amended to read as follows: 74-8501. (a) There is hereby created the commission on access to services for the medically indigent and the homeless, hereinafter referred to as the commission, which shall consist of ~~nine~~ 11 members as follows: (1) Five members appointed by the governor who shall represent the general public; (2) one member appointed by the president of the senate from among the members of the senate; (3) one member appointed by the speaker of the house of representatives from among the members of the house of representatives; (4) one member appointed by the minority leader of the senate from among the members of the senate; ~~and~~ (5) one member appointed by the minority leader of the house of representatives from among the members of the house of representatives; (6) one member appointed jointly by the president of the senate and the minority leader of the senate from among the members of the senate; and (7) one member appointed jointly by the speaker of the house of representatives and the minority leader of the house of representatives from among the members of the house of representatives. Of the members appointed by the governor, not more than three such members shall be providers of health care services.

(b) The members of the commission shall be appointed for terms which shall expire upon the date of expiration of this section under K.S.A. ~~1987~~ 1988 Supp. 74-8505 and amendments

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thereto. Upon the vacancy of a position on the commission, the person appointing the member whose position is vacant, or the successor to the position of the person appointing such member, shall appoint a person to fill such vacancy.

(c) The first person appointed by the governor shall call the first meeting of the commission and shall serve as temporary chairperson of the commission until a chairperson is elected under this subsection (c). The commission shall elect annually a chairperson and vice-chairperson from among the members of the commission who are legislators. The commission shall meet on the call of the chairperson or upon the request of ~~five~~ six members of the commission. ~~Five~~ Six members of the commission shall constitute a quorum.

Sec. 2. K.S.A. 1988 Supp. 74-8505 is hereby amended to read as follows: 74-8505. The provisions of K.S.A. ~~1987~~ 1988 Supp. 74-8501 to 74-8505, inclusive, and amendments thereto, shall expire ~~18-months-from-the-date-of-appointment-of-the-last-member appointed-to-the-commission~~ on December 31, 1989.

Sec. 3. K.S.A. 1988 Supp. 74-8501 and 74-8505 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

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