Approved 2-21-89
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 13, 1989 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisors Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:

Charles Konigsberg, Jr., M.D., Director, Division of Health, KDHE
Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine
William Wade, D.O., Representative of Aids Care Team, St. Francis Hospital
Chip Wheelan, Director of Public Affairs, Kansas Medical Society
Donald Hatton, M.D., Kansas Medical Society
Gordon Risk, M.D., A C L U of Kansas
Sherman A. Parks, Jr., Executive Director, Kansas Chiropractic Association

The chairman called attention to the minutes of February 6,7,8, and 9, 1989 which will be placed before the committee for approval or correction on Tuesday.

Senator Walker requested a committee bill concerning Residential Handicapped accessibility tax credit and moved that the committee accept this bill. Senator Hayden seconded the motion. The motion carried. (Attachment 1)

Charles Konigsberg, Jr., MD, appeared concerning SB-135 stating that this this bill would require physicians to report the names of individuals who test positive for the Human Immunodeficiency Virus. At the present time the syndrome, AIDS, is reportable to the KDHE, but infections with the HIV virus are not. Following questions by the committee Dr. Konigsberg stated it was the feeling of his department that deferrment of this legislation would be preferable. Comprehensive legislation covering all aspects of the Aids program would possibly be looked at next year. (Attachment 2)

Harold Riehm, Kansas Association of Osteopathic Medicine introduced William Wade, D.O., who appeared in opposition to SB-135.

William Wade, D.O., told the committee that less than 10 states require mandatory reporting of HIV. He further stated that SB-135 proposed to revise SB-686 of last year which was the product of many hours of work and consideration. He further stated the practice of statistical sampling and surveillance can be adequately achieved through reporting of HIV positive persons to state health officials by utilizing case identifiers with nothing to be gained by requiring names and addresses. (Attachment 3)

Chip Wheelen, Director of Public Affairs, Kansas Medical Society, appeared to introduce Donald Hatton, M.D., Kansas Medical Society.

Donald Hatton, M.D., told the committee that the Kansas Medical Society opposed SB-135. Dr. Hatton stressed the fact that Human Immunodeficiency Virus is not analogous to other sexually transmitted diseases and it was important that Kansas laws contiunue to reflect policies that will encourage at risk populations to present themselves for HIV testing and counseling that should accompany such laboratory tests. (Attachment 4)

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10:00 a.m./~~p.m.~~ on February 13, 1989

Gordon Risk, M.D., speaking in opposition to SB-135, told the committee that the ACLU of Kansas opposed mandatory reporting of HIV positive results last year on the grounds that it would discourage individuals from getting themselves tested and from becoming informed as to their HIV status. He further stated that individuals will remain ignorant of their condition should this bill be passed and his organization expected passage would increase transmission of the HIV virus. (Attachment 5)

Sherman Parks, Jr., Kansas Chiropractic Association, appeared to request a committee bill which would identify who, in the state of Kansas, could deal with "Manipulation" and "Adjustment" procedures. (Attachment 6)

Senator Anderson moved, with a second by Senator Strick, to introduce this bill. The motion carried.

The meeting adjourned at 10:50 a.m. and will convene at 10:00 a.m. on February 14, 1989 in room 526-S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE February 13, 1989

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
ELIZABETH E. TAYLOR	TOPEKA	KS ASSO OF LOCAL HEALTH DEPTS
LAURA EPLER	TOPEKA	KDHE
Gordon Risk	Topeka	ACLA
Matt Truell	Topeka	AP
Charles Konigsberg, M.D.	TOPEKA	KDHE
R K Baker DVM	Topeka	KDHE
KAREN C. TAPPAN MPA	TOPEKA	KDHE
[illegible]	Topeka	KDPS
[illegible]	"	A.R.L.
[illegible]	Topeka	[illegible]
DW Hatton MD	Lawrence	KMS
Chip Wheelen,	Topeka	KMS
[illegible]	Topeka	KDHE
GARY Robbins		KSOPTOM
Tom Bell		KS Hosp. Assn.
KEITH R LANDIS		CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Sherm. Parks, Jr.		KS Chiropractic Assn.
Ray Petty		Topeka IL Res. Center

STATE OF KANSAS

DOUG WALKER
SENATOR, 12TH DISTRICT
MIAMI, BOURBON, LINN,
ANDERSON, ALLEN AND
NEOSHO COUNTIES
212 FIRST
OSAWATOMIE, KANSAS 66064
(913) 755-4192 (HOME)
(913) 296-7380 (STATE CAPITOL)

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

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

MEMORANDUM

February 2, 1989

To:

From: Doug Walker

Re: Residential Handicapped accessibility tax credit

PROPOSED CHANGES

Income	% Tax Credit
$0 -$15,000	75%
$15,000 - $20,000	65%
$20,000 - $25,000	60%
$25,000 - $30,000	50%
$30,000 - $35,000	40%
$35,000 - $40,000	30%
$40,000 - $50,000	15%
$50,000 and over	0

SP&W
2-13-89
Attachment 1

Schedule

K 37 KANSAS HANDICAPPED ACCESSIBILITY CREDIT

Name of Taxpayer (As shown on form to which attached) | Social Security Number or Kansas File Number

Federal Identification Number

1. Address of principal dwelling or building on which you are claiming the handicapped accessibility credit.

(Street address)

(City and state)

Please attach a detailed description of the alterations made.

2. Date alterations were completed making the dwelling or building accessible to the handicapped or of equipment usable for the employment of the handicapped.

(Month) (Day) (Year)

3. Were the alterations made on:
   - ☐ personal residence
   - ☐ building or facility
   - ☐ equipment
   - ☐ other (specify) _____

4. Were the alterations made on:
   - ☐ an existing structure
   - ☐ new construction
   - ☐ major remodeling
   - ☐ new equipment
   - ☐ existing equipment

5. Do the alterations comply with the American National Standards Institute criteria?
   ☐ Yes ☐ No

6. Cost incurred in making principal dwelling or business facility accessible to the handicapped or of equipment usable for the employment of the handicapped:
   a. Capitalized expenditures and/or deducted business expenses specifically attributable to the elimination/adaptation of an existing architectural barrier for the purpose of making a building/facility accessible to the handicapped
   b. Capitalize expenditures and/or deducted business expenses specifically attributable to the modification or adaptation of a building or facility or of equipment which modification or adaptation is for the purpose of employing the handicapped
   c. Expenses incurred in making a principal dwelling accessible to the handicapped
   d. Total costs incurred: Income tax, fiduciary tax, partnership (Add lines 6a, 6b, and 6c); privilege tax (Enter amount from line 6a)

6a	
6b	
6c	
6d	

PART I—PRINCIPAL DWELLING HANDICAPPED ACCESSIBILITY CREDIT

7. Tax liability (See instructions)
8. Percentage (See schedule provided in instructions)
9. Handicapped accessibility credit (Multiply line 8 by line 6d or $1,250, or line 7, whichever is the lesser amount. Enter on line D44, Part D, back of form 40.)

   If line 7 of schedule K-37 is less than $312.50, complete lines 10 through 13. If line 7 is $312.50 or more, omit line 11 and enter "0" on line 12.
10. Credit or carry forward (See instructions)
11. Multiply line 10 by proper ratio (See instructions)
12. Refund (Subtract line 7 from line 11)
13. Handicapped accessibility credit carry foward (See instructions)

7	
8	%
9	
10	
11	
12	
13	

PART II—BUSINESS HANDICAPPED ACCESSIBILITY CREDIT

14. Depreciation claimed on capitalized expenditures and deducted on federal return (See instructions. Attach schedule.)
15. Expenses deducted against current income on federal return (See instructions. Attach schedule.)
16. Total depreciation and business expenses (Add lines 14 & 15. See instructions.)
17. Handicapped accessibility credit (See instructions)
18. Tax liability (See instructions)
19. Handicapped accessibility credit carry forward (Subtract line 18 from line 17. See instructions.) If line 18 is less than line 17 enter the remainder on line 19. If line 18 is greater than line 17, enter "0" on line 19

14	
15	
16	
17	
18	
19	

INSTRUCTIONS FOR CLAIMING THE HANDICAPPED ACCESSIBILITY CREDIT

The handicapped accessibility credit may be deducted from a taxpayer's Kansas income tax liability if the taxpayer incurs certain expenditures to make an existing personal dwelling located in Kansas or buildings and facilities located in Kansas and used in a trade or business or held for the production of income accessible to the handicapped.

"Accessibility to the Handicapped" Defined: For a building facility to qualify for the handicapped accessibility credit the specifications for making the building and facilities accessible and usable by the physically handicapped must meet the specifications adopted October 31, 1961 and revised on March 3, 1980 by the American National Standards Institute, 1430 Broadway, New York, New York 10018, or any modifications adopted by rules and regulations of the Director of Architectural Services pursuant to K.S.A. 58-1301 and amendments thereto.

"Building or Facility" Defined: A building facility means any building, structure, recreational area, street, curbing or sidewalk, or access thereto, or any accommodation in any building, structure or recreational area, including bathrooms, toilet stalls, dining areas, drinking fountains, phone booths, and lodging rooms or quarters.

"Expenditures for the Purpose of Making All or Any Portion of an Existing Building or Facility Accessible to the Handicapped" Defined: Expenditures for the purpose of making all or any portion of an existing building or facility accessible to the handicapped means only those expenditures specifically attributable to the elimination adaptation of an existing architectural barrier, which elimination adaptation is for the purpose of making an existing building or facility accessible to the handicapped. The expenditures shall not include any part of any expense paid or incurred in connection with the construction or comprehensive renovation of a building/facility, or the normal replacement of depreciable property, or the construction of a building or facility addition.

"Expenditures for the purpose of making all or any portion of a building or facility or of equipment usable for the employment of the handicapped" Defined: Expenditures specifically attributable to modifications or adaptation of any existing building or facility or of equipment, which modification or adaptation is for the purpose of employing the handicapped.

Enter the taxpayer's name and social security number, or Kansas file number and federal identification number, whichever is applicable, on the line provided.

Line 1—Enter the address of the principal dwelling or building or equipment on which you are claiming the handicapped accessibility credit.

Line 2—Enter the month, day, and year the alterations were completed making the dwelling or building or equipment you are claiming the credit on accessible to the handicapped

Line 3—Indicate the type of structure or equipment involved. If "other" is checked please specify what facility was made accessible to the handicapped.

Line 4—Indicate if the alterations were made to an existing structure or equipment or to new construction or remodeling or equipment. If new construction or major remodeling or equipment is checked you cannot claim a credit against your tax liability.

Line 5—Indicate if the alterations are in compliance with the American National Standards Institute criteria. If "no", you do not qualify for the handicapped accessibility credit.

Line 6—Costs incurred in making your principal dwelling or business facility accessibility to the handicapped or of equipment usable for the employment of the handicapped are to be used in determining your handicapped accessibility credit. In most instances the expenditures would be capitalized and depreciated over the life of the improvement However, any expenses that were not capitalized, but deducted as current expenses, will be recognized in computing your handicapped accessibility credit

Line 6a—Enter the capitalized expenditures and or business expense deductions that were specifically attributable to the elimination adaptation of an existing architectural barrier for the purpose of making a building or facility accessible to the handicapped.

Line 6b—Enter the capitalized expenditures and or business expense deductions that were specifically attributable to the modification adaptation of a building or facility or of equipment which modification or adaptation is for the purpose of employing the handicapped.

Line 6c—Enter the total expenses incurred in making your personal dwelling accessible to the handicapped

Line 6d—For income tax, fiduciary tax, and partnership purposes, add lines 6a, 6b, and 6c and enter total on line 6d

For privilege tax purposes, enter amount from line 6a on line 6d

PART I—PRINCIPAL DWELLING HANDICAPPED ACCESSIBILITY CREDIT

Line 7—Enter on line 7 your Kansas income tax liability after deducting all credits other than Kansas handicapped accessibility credit.

Line 8—The applicable percentage to be used on line 8 will be determined by the following table:

Taxpayers Kansas Adjusted Gross Income			Percentage of expenditure eligible for credit
$ 0	to	$ 5,000	75%
5,000.01	to	6,000	70%
6,000.01	to	7,000	65%
7,000.01	to	8,000	60%
8,000.01	to	9,000	55%
9,000.01	to	10,000	50%
10,000.01	to	15,000	40%
15,000.01	to	20,000	30%
20,000.01	to	25,000	20%
25,000.01	to	30,000	10%
30,000.01	and over		0

Line 9—Enter on line 9 the amount which is the percentage on line 8 multiplied by the amount on line 6d, or $1,250, or line 7, whichever is the lesser amount. Enter this amount on line D44, Part D, on the back of form 40. If line 7 of schedule K-37 is $312.50 or more, omit line 11. Enter "0" on line 12 and proceed to line 13.

Line 10—If credit has not been claimed in a prior year enter amount which is the percentage on line 8 multiplied by the amount on line 6d or $1,250 whichever is less. If credit has been previously claimed enter amount carried forward from prior years.

Line 11—If this is the first year in which a credit has been claimed enter amount which is one-fourth (¼) of line 10. If this is the second year in which a credit has been claimed enter amount which is one-third (⅓) of line 10. If this is the third year in which a credit has been claimed enter amount which is one-half (½) of line 10. If this is the fourth year in which a credit has been claimed, enter amount which is on line 10.

Line 12—Enter on line 12 amount which equals line 7 subtracted from line 11. (Also enter on line 20, on the front of form 40.)

Line 13—Enter amount which equals line 10 less the sums of line 9 and 12. This will be the amount that should be carried forward to your next years' income tax return.

PART II—BUSINESS HANDICAPPED ACCESSIBILITY CREDIT

Note: The handicapped accessibility credit includes expenditures specifically attributable to the modification or adaptation of equipment which modification or adaptation is for the purpose of employing the handicapped. The credit is for both individual returns and corporate returns, however, the privilege tax credit will not include the provision for adaptation or modification of equipment for employment purposes.

Line 14—Enter the amount of depreciation claimed as a current business expense deduction on your federal income tax return for the capitalized expenditures entered on line 6a and line 6b (attach schedule)

Line 15—Enter the business expenses deducted on your federal income tax return entered on line 6a and line 6b (attach schedule).

Line 16—Enter on line 16 the total of lines 14 and 15. The total depreciation and business expenses on line 16 is a Kansas modification addition in arriving at Kansas taxable income. Enter this amount on line A4, Part A, on the back of form 40, line 14b, page 2, form 41, line 11, Part II on the back of form 65, line 5, page 1, form 120, line 5, page 1, form 120S; or line 5, page 1, form 130.

Line 17—Enter on line 17 the handicapped accessibility credit which is the proper percentage of line 6d or $10,000, whichever is less The proper percentage for corporate returns will be 50% while the percentage for privilege tax returns will be 25%. Enter the credit on line D44, Part D, on the back of form 40, line 10, page 1, form 41, line 26, page 1, form 120; or line 19, page 1, form 130.

Line 18—Enter on line 18 the Kansas tax liability from the form on which the credit is being claimed after subtracting the other state tax credit, business and job development credit and solar energy credit

Line 19—If line 17 exceeds line 18 the difference may be claimed as a credit against your Kansas tax liability for the next succeeding taxable year(s), until the total amount of credit has been used However, the credit cannot be carried over after the fourth year succeeding the year the credit was originally claimed

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

Testimony Presented to

Senate Public Health and Welfare Committee

by

Kansas Department of Health and Environment

Senate Bill No. 135

Background

Acquired Immunodeficiency Syndrome (AIDS) is one of the most difficult challenges that has faced public health in this century. The knowledge base about the disease and about methods of control is rapidly changing. We are keeping up with the trends in AIDS control and adjusting our programs as needed.

This bill would require physicians to report the names of individuals who test positive for the Human Immunodeficiency Virus (HIV). Currently, Acquired Immunodeficiency Syndrome (AIDS) is reportable to the KDHE, but infections with the HIV virus are not. While a few states do require reporting of HIV positives, most do not. The federal Centers for Disease Control (CDC) does not require or collect data from the states on HIV positives, nor has the CDC yet advocated such reporting of HIV positives as a public health measure. The CDC is conducting scientific seroprevalence surveys in various locations around the nation to help ascertain the levels of infection among various populations and areas.

The proposed bill would not require reporting HIV positives from laboratories or health care providers other than physicians. The bill does not define what "tested positive" means.

This bill maintains strong confidentiality and anti-discrimination provisions designed to safeguard persons rights in connection with the reporting of names. We are supportive of these safeguards. In addition we support the concept of distributing AIDS educational material to district courts for marriage applicants.

SP&NW
2-13-89
Attachment 2

Issues

The definition of "tested positive" is important to avoid the reporting of single screening tests which are often falsely positive. If this bill is to be passed, we think that in conjunction with passage of this bill, K.S.A. 65-6001 should be amended to reflect a more restrictive definition of "tested positive for HIV." We suggest language such as "Tested positive for HIV means a repeatedly positive screening test together with a positive confirmatory test." The likelihood of a false positive with this definition still exists, but is only around 1 in a 100,000.

There would be some fiscal impact to KDHE to cover expenses of record keeping and the possibility of increased partner notification activities.

The larger question in our minds is the public health value of reporting of HIV positives. The public health rationale for reporting of HIV or, for that matter, any disease is to gain valid information on the level of disease in the community and to allow public health agencies to control outbreaks of disease. The reporting of any disease is only as good as the cooperation of those whose duty it is to report and the voluntary compliance of everyone involved.

We have had much discussion in our department regarding what our position should be with respect to HIV reporting. We recognize that some potential public health benefit could result from enhanced opportunities to counsel persons who are positive and that some additional epidemiological data would be gained. HIV infection has no definitive cure such as syphilis, so that there is no direct way to break the chain of infection. We are left only with the technique of trying to change high risk behavior which requires a high degree of voluntary compliance. Furthermore, individuals who are HIV negative but are engaging in high risk behavior also need the prevention message, but we do not reach them by required HIV reporting. Better data on the levels and patterns of infection in our communities could be gained from special scientific sampling studies that do not necessarily require the reporting of names. The support of professional groups, particularly physicians and persons in the community concerned about confidentiality and discrimination is of concern to us. Without that support, a reporting program would not produce the desired public health benefit. Most states still do not require reporting of HIV infection that is not full blown AIDS. The federal Centers for Disease Control (CDC) has not yet indicated that expanded reporting is an appropriate public health measure.

We feel that KDHE should continue to emphasize voluntary testing and counseling and education as major methods of disease control. The number of individuals reached by the state's voluntary testing and counseling program nearly doubled from 1987 to 1988, involving approximately 9500 opportunities to counsel both positive and negative persons. We are concerned that initiating an HIV reporting program may drive people away from our voluntary testing and counseling sites, thereby decreasing our opportunities to prevent disease by encouraging behavior changes.

Specifically regarding HIV reporting, we think that eventually reporting will be accepted as part of a total approach to the control of AIDS. The Kansas Department of Health and Environment will proceed to develop the support necessary while we continue to emphasize voluntary testing and counseling and education. We are also involving local health departments, the Kansas Medical Society and other interested groups in our policy discussions, so as to hopefully gain some level of consensus and support for our efforts.

Presented By:

Charles Konigsberg, Jr., M.D., M.P.H.
Director, Division of Health
Kansas Department of Health and Environment

TESTIMONY OF DR. WILLIAM E. WADE - Topeka
Senate Bill 135

Monday, February 13, 1989

The increasing awareness of the Human Immunodeficiency Virus (HIV) infection in our society has created increased pressure on physicians, public health officials, legislators and politicians to "do something." The old adage, "haste makes waste" could be applied to no truer situation than legislation dealing with HIV.

Senators Steineger and Reilly have proposed revisions of the laboriously-derived Senate Bill 686 which was eventually passed last year. Their revisions, outlined in Senate Bill No. 135, provide for the addition of mandatory reporting of names and addresses to the Kansas Secretary of Health and Environment of persons having tested positive for evidence of the HIV infection.

Currently, there are less than ten states, including the District of Columbia, in which mandatory HIV reporting with patient identifiers is required. The patient management ramifications of this bill would be deleterious to the public health and welfare of those infected and those not infected in this state.

I am no "Johnny-Come-Lately" to the diagnosis and treatment of persons with HIV infection and the Acquired Immunodeficiency Syndrome ("AIDS"). My involvement in managing persons and their families affected with this infection has spanned the time since this disease was first described in the spring of 1981. My involvement with local, state, national, and international physicians and scientists has afforded me a global understanding of the subtleties of this disease process which is necessary in order to objectively analyze treatment and prevention programs and legislation. Mandatory reporting of identified persons infected with the HIV in Kansas would discourage participation in early testing and treatment and would jeopardize the health and well-being of those currently infected with this virus. According to the November 11, 1988 issue of the Centers for Disease Control's, Morbidity and Mortality Weekly Report (MMWR), from October 1985 through March 1988, over one and one-half million civilian applicants for military service were tested for evidence of infection with HIV. Seroprevalence rates for this group averaged 1.4 per 1000 persons tested. During the latest six-month period reported, seroprevalence rates had dropped to 1.2 per 1000. A dominant trend in this survey was the 50% decline in seroprevalence among white males, who constituted nearly two-thirds of recruit applicants. An additional observation noted in this report was the changes in characteristics and make-up of the applicant population due to increased self-deferral of persons who suspect they have been exposed to HIV. Similarly, some states in which mandatory reporting is required have shown a decrease in persons at-risk for HIV infection availing themselves to testing and possible life-saving medical treatment.

SPH&W
2-13-89
Attachment 3

-OVER-

At a time when anonymous counseling and testing has been underscored by the President's Commission on AIDS, the Kansas Governor's Task Force on AIDS, and physicians and scientists around the country working daily with the ravages this disease perpetrates upon those it affects, backward stepping legislation would be unfortunate at best, and disastrous for some. Widespread voluntary testing and counseling is what is needed in this state. Mandatory reporting of names and addresses of those persons taking a positive approach to their health care management would undermine that process. Concerns for civil liberties demand counseling and testing be anonymous (using a code number or at least not a real name) and voluntary (done freely at a time the individual chooses). Persons who are forced to defer testing and early treatment, due to this proposed legislation, will become aware of their serious medical condition only when a potentially avoidable life-threatening infection presents itself.

Some have suggested the "need to know" from an epidemiologic perspective for statistical purposes. The practice of statistical sampling and surveillance can be adequately achieved through reporting of HIV positive persons to state health officials by utilizing case identifiers related to age, sex, birthdate, and initials. There is nothing to be gained by requiring names and addresses.

Now, more than ever, our challenge is to use all the resources available to deal with HIV disease and its associated complications in a positive and caring manner. In our haste to, "do something," let us not forget the admonition in the Hippocratic Oath: "DO NO HARM."

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

February 13, 1989

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society Chris Steele

SUBJECT: Senate Bill 135, As Introduced

Thank you for this opportunity to express our opposition to SB135. While the sponsors of this amendatory legislation have good intentions, enactment of SB135 would be counterproductive.

It is important to keep in mind that human immunodeficiency virus (HIV) is not analogous to other sexually transmitted diseases. Individuals who have engaged in behavior that may expose them to HIV infection do not experience immediate symptoms of disease. Therefore, they have no compelling reason to seek medical attention. Furthermore, even if a person has knowledge that he or she may be infected, because there is no cure for HIV at this time, the individual has no incentive to be tested. This is why it is so important that Kansas laws reflect policies that will encourage at risk populations to present themselves for HIV testing and the counseling that should accompany such laboratory tests.

It is the counseling component of HIV testing that can have the greatest impact in terms of reduced exposure to the virus. If health care providers and professional counselors can convince individuals to modify their behavior, then progress can be made. Otherwise, unsuspecting sexual partners or abusers of drugs who use intravenous methods may be exposed to HIV and the rate of infection could spread to more and more victims.

The current policy in Kansas is to preserve the confidential nature of the physician-patient relationship and to provide HIV test sites that allow anonymity of those tested. This encourages individuals to subject themselves to testing and, of course, counseling. Other states that have imposed mandatory reporting of HIV positive individuals have experienced measurable reductions in the number of persons tested. Attached is a copy of an article from "American Medical News" which describes that experience.

It is for these reasons that the Kansas Medical Society supports the provisions of current law passed by the 1988 Legislature and opposes the change reflected in SB135. We urge you to report SB135 adversely. Thank you for your consideration.

CW:lg

Attachment

SP&W
2-13-89
Attachment 4

Mandatory reporting deters antibody testing — studies

By Sari Staver
AMN CORRESPONDENT

Mandatory reporting of the names of people infected with the AIDS virus will cause those at highest risk to forego antibody testing, according to four studies presented at the Fourth International Conference on AIDS in Stockholm.

In one study, researchers from the U. of South Carolina School of Public Health analyzed the changes in attendance at an alternate test site in Charleston after implementation of a statewide policy that required the state health department to be notified of the name and address of any person who tests positive for the AIDS virus at any clinic or medical office.

According to epidemiologist Wayne D. Johnson, the researchers analyzed data on 966 clients who were tested at an alternative site between May, 1985, and May, 1987. Attendance peaked in late 1985, with a sharp decline in early 1986, after mandatory reporting began.

In another study, the Oregon State Health Dept. found that there was a 125% increase in requests for testing by gay men after the state approved a law late in 1986 allowing anonymous testing at public clinics. Previously, the state had required that all public clinics submit the names of people who were infected with the AIDS virus to public health authorities.

In addition to the increased demand from gay men, the researchers also found that there was a 56% increase in testing from prostitutes, a 17% increase from intravenous drug users, and a 32% increase from other clients.

In a third study, researchers at the U. of California, San Francisco, gave anonymous questionnaires to women seeking care at a university-based obstetrics practice in August, 1987.

Although more than 86% of the women said they would agree to confidential HIV testing if it was medically recommended, only 55% said they would agree to recommended testing if names of seropositive people would be reported to public health authorities. In addition, many of the women said they would forgo medical care if antibody testing were required and if names were submitted to health officials.

A fourth study, done by Franklyn N. Judson, MD, and colleagues at Denver's public health department, also found a decline in the number of gay men who underwent antibody testing following passage of a law requiring that the names of seropositive people be reported to public health authorities. Following passage of the law in the fourth quarter of 1985, there was a decline of more than 35% in the number of gay men who were tested.

WHO chief: AIDS discrimination larger threat

By Laurie Abraham
AMN STAFF

The greatest threat to public health is not AIDS itself, but the stigmatization and discrimination that accompany the fatal disease, the director of the World Health Organization told the Fourth International Conference on AIDS.

"If HIV infection or the suspicion of HIV infection leads to stigmatization and discrimination — such as loss of employment or forced separation from family — then those already infected will take steps to avoid detection," Jonathan Mann, MD, warned in the most stirring opening-day speech of the Stockholm meeting.

Echoing a recent report from the Presidential Commission's on the Human Immunodeficiency Virus Epidemic, he called on all countries to assure justice and dignity to AIDS patients.

"How can we expect long-term behavior change in HIV-infected individuals without long-term access to counseling and support?" Dr. Mann asked.

The battle against AIDS would be easier, Dr. Mann continued, if, for example, IV drug use could be effectively prevented, and the international transfusion system were better integrated.

"AIDS remorselessly exposes and highlights the inadequacies, the inequities, the weaknesses in our health care system," he told the crowd of 4,000.

Splitting the pandemic into three periods, he said that in the 1970s, the virus spread across the world, "and we didn't even know it existed."

Between 1981 and 1985, the virus and its transmission modes were discovered, and a screening test was developed. Today, Dr. Mann said, "the world has never seen mobilization of this speed, of this intensity."

What countries are fighting is a virus that now infects at least 5 million people worldwide, according to WHO estimates. About a million of these people are expected to develop full-blown AIDS during the next five years — 10 to 30 times more than now, Dr. Mann said. So far, Asia and Eastern Europe report few cases of acquired immune deficiency syndrome, but recent evidence from Bangkok, Thailand, shows how quickly the disease can spread. In 1985-86, there were no reported cases of intravenous drug users infected with HIV. Last year, that figure rose to 1%, and statistics from the first three months of 1988 show that 16% of IV drug users there are now infected.

"There is no country that can claim immunity from the virus," Dr. Mann said.

S.B. #135

My name is Gordon Risk, and I'm president of the American Civil Liberties Union of Kansas. I'm here today to voice our opposition to S.B. #135. Since I am a physician and psychiatrist I am also directly affected by this bill.

Last year the ACLU of Kansas opposed mandatory reporting of positive HIV testing on the grounds that it would discourage individuals from getting themselves tested and from becoming informed as to their HIV status. We recommended anonymous testing as the best means of accomplishing this end, a recommendation the legislature saw fit to adopt. Subsequent epidemiology, indicating a decline in the number of new AIDS cases in Kansas, as well as nationally, would seem to support the wisdom of this approach. It is also an approach respectful of the civil rights and liberties of the citizens of this state.

This bill, which would require that any physician who "has information indicating that a person has tested positive for HIV" report that information to the secretary of health and environment, would be a giant step backward. Who would want to find out about their HIV status if the result would be a diminution of civil liberties, supervision by the secretary, and breach of confidentiality at the discretion of the secretary, if one tests positive? Who would want to talk about their status with a physician, its impact upon them and their thoughts about how to proceed, if the only certain result is to be reported to the secretary? Individuals will remain ignorant of their condition, and physicians will be required to harm their patients. Since fewer people will get themselves tested, epidemiological studies will be less reliable, and the disease will go underground. This bill can reliably be expected to increase the transmission of the human immunodeficiency virus.

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AIDS UPDATE: DIAGNOSED CASES THROUGH JANUARY 11, 1989, (KANSAS) AND JANUARY 2, 1989, (UNITED STATES)[1]

Table 1.– AIDS Cases and Case Fatality Rate, by Year of Diagnosis.

	Kansas			United States		
Year	Cases	Deaths	Case Fatality Rate	Cases	Deaths	Case Fatality Rate
1981	1	1	100%	293	268	91%
1982	2	1	50%	1,053	941	89%
1983	4	3	75%	2,899	2,617	90%
1984	6	6	100%	5,845	4,886	84%
1985	18	13	72%	10,785	8,664	80%
1986	49	36	73%	17,175	11,891	69%
1987	68	40	60%	24,109	11,851	49%
1988[2]	67	22	32%	20,540	5,155	25%
Total	215	122	57%	82,764	46,344	57%

Table 2.– AIDS Cases, by Transmission Category.

	Kansas				United States			
Transmission Category	Adults Male	Adults Female	Children	Percent	Adults Male	Adults Female	Children	Percent
Homosexual/bisexual male	148	-	-	69%	50,325	-	-	61%
IV drug user	11	3	-	7%	12,529	3,622	-	20%
Homosexual/IV drug user	15	-	-	7%	5,874	-	-	7%
Coagulation disorder	5	0	0	2%	751	22	83	1%
Heterosexual	2	3	-	2%	1,516	2,073	-	4%
Transfusion/blood products	11	5	0	7%	1,297	747	169	3%
Parent with AIDS/at risk	-	-	3	1%	-	-	1044	1%
Undetermined	8	1	0	4%	2,143	519	50	3%
Total	200	12	3	100%	74,435	6,983	1,346	100%

Table 3.– AIDS Cases, Cumulative, by Race/Ethnic Group.

	Kansas			United States		
Race/Ethnic Group	# Cases	% Cases	% Population	# Cases	% Cases	% Population
White, not hispanic	186	87%	91%	47,628	58%	83%
Black, not hispanic	23	11%	5%	21,929	26%	12%
Hispanic and other	6	3%	4%	13,207	16%	6%
Total	215	100%	100%	82,764	100%	100%

Table 4.– AIDS Cases, Cumulative, by Age at Diagnosis

	Kansas		United States	
Age Group at Diagnosis	# Cases	%	# Cases	%
Under 13	3	1%	1,346	1%
13-19	1	0%	335	0%
20-29	57	27%	17,120	21%
30-39	89	41%	38,194	46%
40-49	41	19%	17,348	21%
Over 49	24	11%	8,421	10%
Total	215	100%	82,764	100%

Table 5.– Kansas AIDS Cases, Cumulative, by County of Residence[3]

County	Cases	Deaths	Case Fatality Rate
Johnson	51	29	57%
Wyandotte	45	20	44%
Sedgwick	42	23	55%
Shawnee	20	14	70%
All others	57	36	63%
Total	215	122	57%

[1] Reflects Kansas statistics as compiled monthly; US statistics as compiled weekly. Kansas cases are those reported to KDHE and accepted by the US Centers for Disease Control. Percentages may not total 100 due to rounding.

[2] Reported to date.

[3] Reported only for counties with 10 or more cumulative cases.

9 RS 0873

SENATE BILL NO. _____

AN ACT concerning the Kansas healing arts act; relating to licensees of the healing arts; limiting the performance of certain procedures to licensees; declaring certain acts to be violations and providing penalties therefor.

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

Section 1. As used in this act:

(a) "Manipulation" means the application of directed manual or mechanical forces to the human living body's joints and adjacent tissues to achieve joint motion beyond the passive limit with or without audible release of the joint.

(b) "Adjustment" means the same as manipulation.

(c) "Board" means the state board of healing arts.

Sec. 2. Persons licensed by the board shall be the only persons allowed to perform manipulation on the human living body in the state of Kansas. Such ability to perform manipulation by a person licensed by the board shall not be prescribed, authorized or delegated to any other person unless such other person is licensed by the board. Any person violating this section shall be subject to the penalties of sections 3 and 4, and amendments thereto.

Sec. 3. Any person not licensed by the board who violates section 2 and amendments thereto shall be guilty of a misdemeanor and upon conviction thereof shall pay a fine of not less than $50 nor more than $200 for each separate offense, and a person for a second violation of section 2 and amendments thereto shall be guilty of a misdemeanor and upon conviction thereof shall pay a fine of not less than $100 nor more than $500 for each separate offense.

Sec. 4. The board, in addition to any other penalty

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prescribed under the Kansas healing arts act, may assess a civil fine, after proper notice and an opportunity to be heard, against a licensee for a violation of section 2 and amendments thereto in an amount not to exceed $1,000 for the first violation, $3,000 for the second violation and $5,000 for the third violation and for each subsequent violation. All fines assessed and collected under this section shall be remitted promptly to the state treasurer. Upon receipt thereof, the state treasurer shall deposit the entire amount in the state treasury and credit it to the state general fund.

Sec. 5. Upon the request of the board, the attorney general or a county or district attorney shall institute in the name of the state the appropriate proceedings against any person charged, by complaint to the board, with the violation of section 2 and amendments thereto, and the attorney general, and such county or district attorney, at the request of the attorney general or of the board shall appear and prosecute such actions.

Sec. 6. Sections 1 to 6, inclusive, and amendments thereto, shall be part of and supplemental to the Kansas healing arts act.

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book.