Approved 1/30/90
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by SENATOR RICHARD L. BOND
Chairperson
at

9:00 a.m./~~p.m.~~ on WEDNESDAY, JANUARY 24, 1990 in room 529-S of the Capitol.

All members ~~were~~ present ~~except~~:

Senators Karr, Kerr, McClure, Moran,Parrish, Salisbury, Strick and Yost.

Committee staff present:
Bill Edds, Revisors Staff
Bill Wolff, Research Department
Louise Bobo, Committee Secretary

Conferees appearing before the committee:
Representative Jessie Branson, Kansas
Barbara Gibson, Governor's Commission on Access to Services for the Medically Indigent and Homeless
Senator Ehrlich, Chairman of the Governor's Commission on Access to Services for the Medically Indigent and Homeless
John Alquest, Commissioner, Income Maintenance and Medical Services for SRS
Carlos Cooper, AARP
Deborah Hinnen, American Diabetes Society
Nadine Burch, Silver Haired Legislature

Chairman Bond called the meeting to order at 9:15 a.m.

SB 444 - Establishment of Kansas health benefits program.

Representative Jessie Branson, Vice Chairman, Commission on Access to Services for the Medically Indigent and Homeless, appeared before the committee in support of SB 444 which would abolish the present Kansas MediKan program and create the Kansas Health Benefits Program. Rep. Branson informed the committee that, since the Commission last met, the cost estimates of implementing this program have risen considerably. Since one of the initial goals of establishing this program was to cut costs, a committee member inquired of Rep. Branson if she would still be in favor of the program even though the costs would be greater than the current MediKan program. Rep. Branson replied that she really could not speak for the Commission but, personally, she would because the program would focus more on preventive and primary care. (Attachment 1)

Barbara Gibson, a member of the Governor's Commission on Access to Services for the Medically Indigent and Homeless, spoke before the committee in support of SB 444. Ms. Gibson emphasized that the program would place more emphasis on the care of pregnant women, children and the working poor. (Attachment 2)

Senator Ehrlich, Chairman of the Commission, informed the committee that the Commission worked long and hard on this bill and he hoped the Committee would take a very close look at it. He further explained that the bill originated from SRS and he did not learn until last evening that the costs projections had been increased. Senator Ehrlich said that Mr. Alquist would explain the reasons behind the increase in costs.

Ms. Gibson continued her testimony by stating that SRS had been very helpful to the Commission in drafting this proposal and, in her opinion, the increased numbers probably have to do with definition of terms.

John Alquest, Commissioner, Income Maintenance and Medical Services for SRS, appeared in opposition to SB 444. Mr. Alquest stated that, although SRS has long recognized the need for a medical program to better meet the needs of the medically indigent in Kansas, the agency could not support this proposal because it is not part of the budget for FY 1991. (Attachment 3)

Discussion followed concerning the services offered, the number of people covered under the existing program versus the proposed program, the costs projections, and better definition of services offered. In response to a committee member's question, Mr. Alquest said that the total cost of the program would be $33 million but that depended on the definition of services.

Carlos Cooper, AARP, informed the committee that his organization pledged their continued support of these services and urged that this proposal not be abandoned because the fiscal programs do not match. (Attachment 4)

Deborah Hinnen, American Diabetes Society, Kansas Affiliate, urged the committee to support SB 444. She stated that her organization particularly endorsed the primary and preventive care included in the bill. (Attachment 5)

Nadine Burch, Silver Haired Legislature, presented written testimony to the committee members but time limitation prevented her speaking before the committee. (Attachment 6)

Chairman Bond stated that more information was needed before the committee could consider this bill. He suggested that the Commission on Access Services to the Indigent get together with SRS about cost projections and definition of services. A committee member suggested that the committee should perhaps have some liason with the Commission and Commission members present agreed that volunteers from the Committee would be welcome at their meeting.

Chairman Bond declared the hearing on SB 444 to be in recess until further notice. After reminding the committee members of the Joint House and Senate Insurance Meeting on January 30, 1990, Chairman Bond adjourned the meeting at 10:04 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Wed. Jan 24, 1990

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Nadine Bursch	Topeka, Ks	Silver Haired Legislature
Barbara Gibson	Valley Center KS	Gov-Commission on Access to Services - Med Budget
Dennis Priest	Topeka	SRS
SHIRLEY MARKHAM	TOPEKA	SRS
Tom Bell	"	KHA
Jayne K Wiaroski	TOPEKA	AFSCME-
Bob Cochrane	Wichita	American Diabetes Assn
Debbie Shriner	Augusta	American Diabetes Assn
Chip Wheeler	Topeka	Ks Medical Society
Orville Voth	Lawrence	Silver Haired Legislature
George Goebel	Topeka	AARP-CCTF
Lynda Drew	Topeka	KDOT
BRAD SMOOT	"	Fourth Financial
M. Hawver	"	Capital-Savings
John Algeo	"	SRS
Katie Klasser	Topeka	SRS

STATE OF KANSAS

JESSIE M. BRANSON
REPRESENTATIVE, FORTY-FOURTH DISTRICT
800 BROADVIEW DRIVE
LAWRENCE, KANSAS 66044-2423
(913) 843-7171

TOPEKA

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

HOUSE OF
REPRESENTATIVES

January 24, 1990

TO: Senator Richard Bond, Chair
and Members
Senate Committee on Financial Institutions
and Insurance

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

RE: Support of S.B. 444

Jessie

I appreciate the opportunity to appear before you in support of S.B. 444 which would abolish the present Kansas MediKan program and in its place create the Kansas Health Benefits Program.

The following are provisions and requirements in creating the Kansas Health Benefits Program:

- - Program administered by Secretary of SRS through adoption of rules and regulations.

- - Recipient of the program must be a resident of the state; recipient's current income must not exceed 85% of poverty level; employer, if any, does not offer health insurance benefits; recipient is not covered by a private third-party payor, Medicare or other governmental health insurance or

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state medical assistance program;

- - Dependents of qualified recipients are also covered under program;

- - Recipient pays premium established by Secretary; Secretary shall also establish copayment requirements and may establish deductible requirements;

- - During the first two years of operation, the only benefits available shall be physician services, pharmacy services, preauthorized hospital services and emergency hospital services;

- - Organ transplants would be excluded;

- - After two years operation, program is subject to review by the Governor and Legislature relating to possible expansion of services and poverty level eligibility.

- - Secretary must apply to federal HHS for approval of a demonstration project for a MediKan "buy in" project.

The cost of the proposed program had been projected by SRS to be less than the current MediKan program. However, there has been a last minute development by SRS regarding the cost, presenting a figure which appears to be considerably in excess of what the Commission had previously been told.

SB 444 is the outcome of considerable study by members of the Commission on Access to Services for the Meidcally Indigent. It has

been the concensus of the Commission throughout that there must be more focus on provision of preventive and primary care services if ever the cost of the "MediKan" program can be brought under control and if, indeed, acute services are to be curtailed. However, the very "last minute" development by SRS on cost projection leaves Commission members quite confused.

Thank you for your attention and consideration.

JB:hh

REMARKS TO THE

SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

IN SUPPORT OF S.B. 444
TO ESTABLISH A KANSAS HEALTH BENEFITS PROGRAM

January 24, 1990

by Barbara J. Gibson
Member: Governor's Commission on Access to Services
for the Medically Indigent and Homeless

The Commission on Access to Services for the Medically Indigent and Homeless was created by the 1987 Legislature after interim study of the two related issues of services for the medically indigent and the homeless problem. Recommendations of the Commission were reported to the Legislature and the Governor in December, 1988 and an additional report with recommendations is being completed at this time.

As brief overview of our findings, the Commission has concluded that assuring access to basic health services, whether viewed as an individual right or a societal obligation, is a good investment of resources. Medical indigence is defined by the Commission as the circumstance of being unable to secure health care because of the inability to pay for all or part of such care due to inadequate personal resources, being uninsured, being underinsured, or being ineligible for governmental health benefits. The responsibility for the assurance of health care access is not solely the responsibility of state government, but a joint responsibility of state, federal, and local governments, providers, employers, insurers, and the private sector.

The Commission has studied the current state programs for medical assistance, the eligibility standards, the covered benefits, and the budgets for services to persons eligible for Medicaid and MediKan. This past summer, after receiving information from SRS regarding the

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MediKan program, the Commission began to look at alternative programs to place priority on access to basic health services for a greater number of persons; initial emphasis given to primary and preventive health services for pregnant women, children and the working poor.

At the same time, we were being advised that the current budget for MediKan was going to be insufficient for the remainder of the fiscal year. The population served by this program, numbering approximately 7,160, consists of persons predominently outside the groups recommended for initial program emphasis by the Commission. Nearly 2/3 are adults, most with chronic physical and mental conditions that interfere with prospects for employment. Some are awaiting federal disability decisions. Health service needs and expenditures for the disabled adults are heavily weighted away from primary, preventive services toward inpatient hospitalization, physician services and community mental health centers.

S.B. 444 would establish a state health benefits program that would offer an alternative in place of and not in addition to the existing MediKan program. It would establish a program permitting certain persons with incomes under 85% of the federal poverty level to purchase medical and health care benefits for a monthly premium. The program cannot be a substitute for health insurance currently offered by an employer or for applicable government sponsored health benefits programs. The Secretary of SRS would be authorized to determine the amount of the monthly premium and any deductible or copayment requirements. It is a basic tenet of the Commission that medically indigent persons should contribute to their own health care to the degree they are able to do so.

However, the Commission realizes that state funds are not unlimited. Whenever the needs of medically indigent Kansans exceed

the taxpayers' ability or will to fund medical care for them, there should be a method of determining priorities for persons to be served and services to be offered. Our current dilemma regarding the SRS budget and the MediKan program illustrates just how difficult it can be to rank priority for services and for eligible groups. And, how unfortunate it is to have to reconsider programs mid-year.

Sec. 1.(b) of S.B 444 provides that during the first two years of the proposed Kansas health benefits program, the only medical and health benefits available shall be physician services, pharmacy services, preauthorized hospital services and emergency hospital services, not including organ transplant procedures. These health services, after difficult deliberation, were the priority services identified by the Commission. I support passage of S.B.444 and the restructuring of our state medical assistance program. It is an incremental and workable program Kansas can implement while we urge our federal officials to adopt a system that assures universal access to an adequate level of health care for all Americans.

Thank you for your attention to this issue and the opportunity to share information from the Commission on Access to Services for the Medically Indigent and Homeless.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Winston Barton, Secretary

TESTIMONY REGARDING: SB 444

We appreciate being given the opportunity to present testimony regarding Senate Bill 444. This bill creates a new medical program designed to serve those persons who do not otherwise have health coverage. This group is oftentimes referred to as the "medically indigent." The program would replace the current MediKan program and provide limited health coverage to those individuals and families whose income does not exceed 85% of the federal poverty level. Only physician, pharmacy, preauthorized and emergency hospital services would be provided in the first two years.

Before looking more closely at the program being proposed in this bill, it is important to note what medical coverage currently exists through the Department. Medicaid benefits are available to individuals and families who are eligible for cash assistance under the federal Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. This includes families where one or more children are deprived of parental support due to the absence, disability, or unemployment of one of the parents, and individuals who are aged (65 and older), blind, or disabled based on Social Security criteria. The program also covers children in foster care and subsidized adoptions, pregnant women and infants up to age 1 whose family income does not exceed 150% of the federal poverty level, and children ages 1 to 5 whose family income does not exceed 100% of poverty. This latter group of children will be expanded to include children ages 1 to 6 with incomes up to 133% of poverty beginning April 1, 1990.

For those persons who are ineligible for AFDC or SSI benefits because of excess income and who do not fall under one of the poverty level groups described above, Medicaid coverage is still potentially available based on what is called a "spenddown" procedure. This allows the individual to reduce his or her excess income by deducting medical expenses. The person's income is compared to an income standard and the amount by which the income exceeds the standard creates the spenddown. The spenddown is similar to an insurance deductible in that the person does not gain eligibility until he or she has medical expenses which meet the spenddown amount. The income standards currently used in this program are approximately 55% of poverty for a family of three and approximately 46% of poverty for a family of four.

The Medicaid program provides coverage of most medical services including hospitalization, physician and pharmacy services, and mental health and substance abuse treatment. It is approximately 57% funded by the federal government.

The State has also provided medical coverage to its General Assistance cash population through the State-funded MediKan program. The General Assistance (GA) program serves those individuals who do not qualify for the federal AFDC or SSI programs and who meet certain eligibility criteria. This includes primarily single adults and childless couples where the individuals are age 55 or older or are physically or mentally incapacitated. However, the program also serves

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families where neither parent meets AFDC qualifications (i.e. both parents are present and neither meet the AFDC disability or unemployment criteria). Single adults and childless couples who are otherwise employable do not qualify for the GA program.

The MediKan program provides coverage of most medical services including hospitalization and physician and pharmacy services but to a more limited degree than Medicaid. It is totally state-funded. Only those persons who are eligible for a GA cash grant can receive MediKan currently. The standards used in the program are fairly low equating to approximately 40% of poverty for a single incapacitated person and 46% of poverty for a family of three. If the person's or family's income exceeds these standards, there is no further medical coverage available. The Governors FY 91 budget recommends the total elimination of the MediKan program. It's cost in FY 91 would have been over $22 million.

As extensive as these programs have been, there is still a substantial number of Kansans who have no health coverage either through public or private sources. The State Commission on Access to Services for the Medically Indigent and Homeless has estimated that as many as 380,000 Kansans are without health insurance coverage either because of cost or the lack of available health plans through the work place. Most of these individuals are unable to obtain preventive or basic health care services and generally wait until they are acutely ill before presenting themselves or their children at the hospital emergency room where they presume they cannot be turned away. This not only leads to a decline in the health and well-being of our population but also leads to increased costs for the physicians, hospitals and the State as acute care is more expense to fund that preventative medicine.

Senate Bill 444 addresses these problems by providing an opportunity for Kansas residents whose incomes do not exceed 85% of the federal poverty level to obtain limited medical coverage geared toward preventative care as well as emergency acute care needs. As mentioned previously, this new program would replace the current MediKan program and use the monies available to cover a broader spectrum of the population. Besides the current General Assistance population, the program would also be available to any individual or family whose income falls within the 85% of poverty level. That level equates to the following standards:

Household Size	Amount Income 85% of Poverty	Amount Income 100% of Poverty
1	$ 5,083	$ 5,980
2	$ 6,817	$ 8,020
3	$ 8,551	$10,060
4	$10,285	$12,100

The Department does have several concerns in regards to the current wording of the bill.

First, clarification is needed in section 1 (b) regarding covered services. Services that qualified individuals will receive are physician and pharmacy services and preauthorized hospital services. It is presumed that limitations

will be established for physician and pharmacy services but this is not stated in the bill. If this assumption is correct, we would urge the committee to clarify that limitations similar to those in Medicaid should be established. Without this there will be no control over services or cost. Examples of limitations in the Medicaid program for physicans are 12 office visits a year, office visits and surgical procedures not covered on the same day, and one consultation visit in 60 days. Pharmacy limitations are coverage of specified drugs only for certain diagnoses and limitations on the number of days a drug will be covered.

With respect to hospital services it is apparently intended that preauthorization would limit services and cost. However, in the absence of specific guidance in this matter it must be presumed that admissions which are medically necessary would be approved for reimbursement. This is our current practice in the MediKan program and the cost of these admissions is reflected in the fiscal impact.

Preauthorization means there would be no admissions allowed for reimbursement until approved in advance. This is a very costly process which would require extensive staffing. In addition, because information would be lacking simply because the work up of the patient's condition had not been done or the seriousness not known, approval would be given when in reality admission was not necessary. It is recommended admissions be reviewed after discharge as in the Medicaid program. Medicaid Necessity criteria are established and 100% of all admissions could be reviewed, a random sample reviewed or both depending on the diagnosis. Those that did not meet criteria would be denied. Medical Necessity would be defined in the criteria. Further limitation could also be set by not covering selected procedures which would include transplants, as in the bill, and other new pioneering procedures.

Second, section 1 (f) requires the Secretary to apply for approval of a demonstration project to gain potential federal funding for the new program. It should be noted that no authority currently exists in federal statute or regulations for such a project and, thus, the prospect of this effort succeeding is minimal. As such, the State would need to be prepared to fund the program for the foreseeable future based on all State funds.

Third, in terms of the definition of who a "qualified individual" is in section 1 (h), the requirement that the individual's employer not offer medical and health insurance benefits is problematic. Such provision could potentially eliminate eligibility for a number of persons whose employers offer health insurance but at a substantial cost or with only catastrophic coverage. As any employer coverage would be viewed as first payor on medical services received by individuals qualifying for this new program, the Department would recommend this criteria be eliminated from the bill.

Also, in regards to coverage through private third-party payors, Medicare, or other governmental health insurance or State medical program, the Department would recommend that the private third-party payor criteria be eliminated for the same reasons as mentioned above. Once again, the existence of such sources does not guarantee adequate coverage for the individual and may carry such high

deductibles and co-insurance that for all intents and purposes the insurance rendered worthless except in the most catastrophic of situations. Any of these third-party payors would be considered as first payors for eligible clients. Participation should, however, continue to be limited to those not otherwise covered by Medicare or other government programs such as Medicaid as to do otherwise would shift additional costs from federal to State funds. This would include those persons potentially eligible for Medicaid based on the spenddown concept described earlier.

Despite the concerns and recommendations cited above, the Department cannot in the final analysis support the bill. Although we concur with the concept of retaining and remolding the MediKan program, we cannot ignore the budget shortfalls which exist for the remainder of this fiscal year and for the next fiscal year. The cost of these more limited services to the existing MediKan clients would still reach $19.8 million in FY 1991. Adding new clients now above current income limits, but below 85% of the poverty level, would add an additional $14.0 million. As we face a budget deficit of more than $50 million for that fiscal year based on current program projections, there are simply insufficient funds to revive and expand MediKan program.

In summary, although SRS has long recognized the need for a medical program to better meet the needs of the medically indigent in this State, the agency cannot recommend the passage of S.B. 444 due to its current budgetary problems. If such a program was established, there is a danger that other needed programs operated by SRS would have to be cut or eliminated altogether.

John W. Alquest
Commissioner, Income Maintenance
and Medical Services
296-6750

KANSAS STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mr. Robert E. Burkholder
617 North Wall Street
Buhler, KS 67522
(316) 543-2705

VICE CHAIRMAN
Dr. Lawrence A. Bechtold
1106 S. Governeour Road
Wichita, KS 67207
(316) 684-2350

SECRETARY
Mrs. Margaret J. Miller
6807 E. Bayley
Wichita, KS 67207
(316) 686-2555

TESTIMONY ON SB 444
AARP STATE LEGISLATIVE COMMITTEE
SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
January 24, 1990

Mr. Chairman and members of the Senate Public Health and Welfare Committee:

I am Carlos Cooper, a member of the Capital City Task Force of the State Legislative Committee of the American Association of Retired Persons.

For several years the Kansas State Legislative Committee of AARP has had a priority provision for a "comprehensive program to improve access to health care for uninsured persons." Once again, this past summer, our committee considered the data and research on this matter. You will find attached to this testimony a summary of our current review and research on the need for availability of adequate health care for an estimated 370,000 Kansans.

The State Legislative Committee of AARP supports passage of SB 444 which would provide, if enacted and funded, the opportunity for certain persons, as defined in SB 444, to purchase medical and health care coverage through SRS.

We commend Senator Ehrlich and Senator Anderson for introducing this bill in behalf of the "Commission on Access to Services for the Medically indigent and Homeless." We pledge our support to secure enactment and adequate funding.

We thank you for the opportunity to testify in support of SB 444.

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TION PAPER FOR KAN .S AARP 1990 LEGISLATIVE P' 'ORITIES

ACCESS TO HEALTH CARE FOR UNINSURED PERSONS

Problem: About 14% of the Kansas population is either uninsured, ineligible for health assistance programs, or unable to pay for health care. This widely-varied group includes rural and urban residents, the employed and the unemployed, elderly adults, young adults, teen-agers, and children. A large share (42%) of state and federal support to this group is presently spent on adult care homes. Meanwhile, children and younger adults (including pregnant teen-agers) from low-income families are not adequately provided with basic health care.

Solution: The State should adopt policies that ensure that all Kansans have access to quality health care, with fair and adequate reimbursement to all providers.

Proposal: A coordinated program of federal, state, local, and private action should be developed that continues to assist persons in care homes and also provides basic medical assistance to uninsured or under-insured younger adults and children. This should include:

(1) Developing outreach programs to increase the number of eligible citizens who participate in government health care programs.

(2) Developing innovative health care programs for the medically uninsured, including:
..Establishing community health clinics to offer preventive and other basic medical care (including pre-natal care) to the uninsured and underinsured.
..Establishing programs that enable advanced nurse practitioners and related professionals to play a larger role in providing primary care services.
..Increasing the involvement of public health departments in health care to the uninsured and underinsured.
..Developing creative ways of funding these programs from a combination of federal, state, local, and private sources.

(3) The extension of insurance coverage for basic health care by procedures such as:
..Assisting small employers to join together in insurance pools to reduce the cost of health insurance coverage.
..Using tax credits to encourage small businesses to provide basic health insurance for their employees.
..Permitting low-income persons to "buy into" state-funded medical care programs.
..Providing medicaid coverage for pregnant women and children up to twice the federal poverty level.

Position: The Kansas State Legislative Committee urges the passage of legislation to establish such programs.

Ho. .any Kansans are without health insurance? 1986 figures suggest nearly a half million. In a Wichita practice of over 7,000 patients with diabetes, 237 people are documented to have no insurance. In that same practice, 630 have Medicaid and/or MediKan. That is nearly 11 ½% of that patient population who for financial reasons likely, have to rely on the State for health insurance; or gamble on having no major health crisis because they have no insurance. That number does not count the "Medical Untouchables"; those people we can't count because they can't afford care and are too proud to step forward and ask for help.

Diabetes is an expensive disease. The Diabetes Forecast Magazine calculates the annual costs of insulin, syringes, blood testing supplies, labwork and doctor visits at just over $2,000 per year for the person with insulin dependent diabetes.

If people try to cut corners, and not do blood testing for instance...when they get sick, the doctors won't have any blood sugar values to help make insulin adjustments on an out-patient basis. Those people will likely develop extremely high blood sugars and end up in the emergency room. The next step is Intensive Care. I don't want to spend my tax dollars that way if it's a Medicaid or MediKan Patient. If they have no insurance, I will likely pay indirectly thru increases in health care costs. Inadequate health care on the front end leads to higher costs on the back end. Not just hospitalizations due to illnesses, but eventually kidney disease and dialysis.

People with no insurance have no resources. The cost of health insurance is prohibitive.

A family plan can easily exceed $400/month. A family trying to survive on minimum wage of about $7,000/year would not be able to afford $4800 of health insurance. They would also not qualify for Medicaid or MediKan. A "buy-in", as proposed by SB 444, if reasonably priced, could be a God-send to the working poor. It could offer sound, basic health coverage to a group of Kansans now not covered by anything. With eligibility at 85% of the poverty level, the number of people able to access the buy-in will be somewhat limited. But still, once implemented, and evaluated that level could be amended if indicated.

The problem of Kansans without health insurance is of grave concern to our citizens, particularly people with chronic diseases. We applaud the extensive work of Senator Ehrlich, Representative Branson and the Commission on Access to Services for the Medically Indigent and Homeless.

On behalf of the American Diabetes Association-Kansas Affiliate, may I share our support of the concept of SB 444.

Deborah Hinnen RN MN CDE
Program Manager
Diabetes Treatment Center at
St. Joseph Medical Center

Assistant Clinical Professor
University of Kansas
School of Medicine-Wichita

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Testimony on SB 444 by Nadine Burch, SHL

I will address the elderly segment of population who need this bill enacted, i.e. persons between the ages of 60 and 64. These are people who are not employees, and can not afford to purchase coverage and are ineligible for Medicare.

You can help these people by recommending SB 444. This group of people most times are not poor enough to qualify for Medicaid and yet do not have enough income to purchase insurance.

We think that particularly vulnerable are these people (60-64) who in many instances have been forced to retire because of failing health. Private employers very seldom carry insurance on retirees and to change from group to individual coverage is very expensive.

This bill is written in such a manner that it can be fiscally flexible - also the section advocating a demonstration project is a positive element.

We have finally enacted a Senior Care Act, which implements a sliding scale fee. We strongly advocate SB 444 which enables those who can pay part of their coverage to do so.

Thank you.

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