Approved: 1/24/95
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Dick Bond at 9:09 a.m. on January 19, 1995 in Room 529-S of the Capitol.

All members were present.

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
June Kossover, Committee Secretary

Conferees appearing before the committee: David Ross, Kansas Association of Life Underwriters
Sanford Kaufman, Connaught Laboratories
Jim Caccamo, Partnership for Children
Mary Kopp, M.N, Kansas State Nurses Association
Meyer Goldman, Humana
Steven Potsic, M.D., KS Department of Health & Environment
Richard Brock, Insurance Consultant
Chip Wheelen, Kansas Medical Society

Others attending: See attached list

David Ross, KALU, appeared before the committee to request introduction of legislation to amend HB 2618, which was enacted during the 1994 session, to provide a method for dispute resolution on claims. (Attachment #1.) Senator Lee moved to introduce this legislation. Senator Praeger seconded the motion; the motion carried.

Senator Steffes requested introduction of legislation dealing with insurance fraud to correct language in the legislation enacted last session. (Attachment #2.) Senator Lee made a motion, seconded by Senator Lawrence to introduce this legislation. The motion carried.

Senator Lawrence moved to approve the minutes of the meeting of January 18 as submitted. Senator Praeger seconded the motion. The motion carried.

The chairman opened the hearing on **SB 36**, which mandates the coverage by insurance carriers of immunizations for children from birth to two years of age. Sanford Kaufman, Connaught Laboratories, appeared as a proponent of this legislation, explaining that the modest increase in insurance premiums would be more than offset by the projected savings in treatment costs. (Attachment #3.) Chairman Bond pointed out to the committee that this legislation represents an insurance mandate since all domestic policies would be required to provide coverage for immunizations from birth to two years of age, and that Kansas law requires that an impact statement be provided. This impact statement has been provided by Mr. Richard Brock, former Chief Assistant to the Commissioner of Insurance. (Attachment #4.)

Senator Praeger questioned whether we have exclusions for religious reasons. It was clarified that this bill does not mandate immunization, merely that insurance companies must provide coverage for immunization.

Jim Caccamo, Partnership for Children, appeared in support of this bill, stating that it makes economic and emotional sense to immunize children as early as possible. (Attachment #5.)

Mary Kopp, Kansas State Nurses Association, presented facts and figures in support of this legislation and underlined the need for infants to obtain age appropriate immunizations. (Attachment #6.)

Meyer Goldman, Humana, testified in favor of this bill, stating that as a matter of policy, Humana opposes mandates; however, they strongly support the immunization of infants. (Attachment #7.)

Dr. Steven Potsic, Kansas Department of Health and Environment, testified as a proponent, stating that this bill should encourage parents to have their children immunized by private physicians, thereby reducing the number of children requesting immunization from local health departments. (Attachment #8). In response to Senator Bond's question, Dr. Potsic informed the committee that the current method of tracking immunizations does not accurately reflect the number of immunized children in the state and that the state is working on a new system to track immunizations. Software is being developed and, optimistically, will be phased in during 1995, but it will be very difficult to include all private practitioners.

Chip Wheelen, Kansas Medical Society, appeared in support of this legislation and requested an amendment to raise the age limit from two to five years. (Attachment #9). Mr. Wheelen pointed out that the financial impact statement did not specify the maximum of age two and that increasing the age limit to five should have no additional fiscal impact. Dick Brock stated that it was not suggested in his fiscal impact statement that the age limit be increased to age five because this would provide insureds with more opportunity to delay getting their children inoculated.

Senator Lee asked for clarification regarding the age: does age two mean 24 months or through the child's second year? The bill as written, is intended to mean up to age two, or 24 months.

Bob Kennedy, Assistant to Insurance Commissioner Sebelius, stated that the Insurance Commissioner supports this bill very strongly and will be willing to provide education to the public regarding early immunization.

Kansas Action for Children (Attachment #10), and Patrick Hurley and Company, representing the Kansas Academy of Family Physicians (Attachment #11), presented written testimony.

There being no further conferees, the hearing on **SB 36** was closed. Senator Praeger made a motion to amend the bill to raise the age limit to five years of age. Senator Lee seconded the motion. Following extended discussion regarding the need/benefits for increasing the age limit, the motion failed.

Senator Lee moved to amend the bill to increase the limit to 36 months. Senator Praeger seconded the motion. The motion carried.

Senator Praeger made a motion to pass the bill favorably as amended. The motion was seconded by Senator Petty. The motion carried. Senator Praeger will carry this bill on the Senate floor.

The committee adjourned at 9:59 a.m. The next meeting is scheduled for January 24, 1995.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 1-19-95

NAME	REPRESENTING
David Ross	Ks. Assn. Life Underwriters.
Roger L. Goldman	Humana HCP.
Dick Brock	SCIS
Jim Caccamo	Partnership for Children
John Federico	Pete McGill + Assoc
Sandy Kaufman	Connaught Labs
Bob Mechtzelman	SRS
Larry Kuhn	Glaxo
Steven Empson	Heim, Ebert, Weir, Child.
Chip Wheelen	KS Medical Society
Kathy Peterson	Connaught Labs
John Peterson	Glaxo
Brad Smoot	BCBS/KMHCA
Steve Keadey	KPTA
Norm Wicks	KASB
Rich Guthrie	Health Midwest
Mary Kopp	Kansas State Nurses Assoc.

K·A·L·U

The Kansas Association of Life Underwriters

216 W. 7th Street, P.O. Box 2639 • Topeka, Kansas 66601 • (913) 234-3491 • FAX (913) 234-3713

Mr. Chairman, Members of the Committee,

I am David Ross representing the Kansas Association of Life Underwriters. The Kansas Association of Life Underwriters membership consists of approximately 2,000 insurance agents across the state of Kansas. I appear before you today to seek introduction of a bill that will assist policyholders in the settlement of their health insurance claims.

Last year, the legislature adopted HB2618. This bill required that health insurance policies that made claim settlements based upon "reasonable and customary charges" had to define that term or if claims were settled using a statistical sample it had too come from a recognized authority. Unfortunately for policyholders, if the provider disputes the benefit amount to be paid and the insurer does not believe they should pay more, the policyholder is being stuck with a bill for the difference.

We propose that claim settlements based upon these two options include within their enabling provisions a method for dispute resolution.

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Attachment #1

exception or reduction shall be included with the benefit provision to which it applies; ~~and~~

(6) each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; ~~and~~

(7) it contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner of insurance*; and*

(8) any provision purporting to base the payment of benefits on "usual, customary and reasonable charges" or a standard of similar import is specifically defined; or the determination of payable benefits is developed from a statistically valid sample which: (A) Equitably recognizes geographic variations; (B) is produced at ~~no less than six month intervals~~ least every six months*; and (C) is collected on the basis of the most current codes and nomenclature developed and maintained by recognized authorities.*

~~(B)~~ *(b)* If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner of insurance that any such policy is not subject to approval or disapproval by such official, the commissioner of insurance may by ruling require that such policy meet the standards set forth in subsection ~~(A)~~ *(a)* of this section and in K.S.A. 40-2203 *and amendments thereto*.

Sec. 2. K.S.A. 40-2202 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Either provision for determination of payable benefits must contain a method for resolution of disputes arising from claims for benefit amounts greater than benefit amounts determined utilizing these provisions.

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SENATE BILL NO. ____

By Committee on Financial Institutions and Insurance

AN ACT concerning insurance; coverage of certain claims; amending K.S.A. 1994 Supp. 40-2,118 and repealing the existing section.

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

Section 1. K.S.A. 1994 Supp. 40-2,118 is hereby amended to read as follows: 40-2,118. (a) For purposes of this act a "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

(b) Except as otherwise specifically provided in K.S.A. 21-3718 and amendments thereto and K.S.A. 44-5,125 and amendments thereto, a fraudulent insurance act shall constitute a severity level 6, nonperson felony if the amount involved is $25,000 or more; a severity level 7, nonperson felony if the amount is at least $5,000 but less than $25,000; a severity level 8, nonperson felony if the amount is at least $1,000 but less than $5,000; a severity level 9, nonperson felony if the amount is at least $500 but less than $1,000; and a class C nonperson misdemeanor if the amount is less than $500.

(c) In addition to any other penalty, a person who violates this statute shall be ordered to make restitution to the insurer

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or any other person or entity for any financial loss sustained as a result of such violation. ~~An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act.~~ If a person has been convicted through judicial adjudication of committing a fraudulent insurance act, an insurer shall not be required to provide first party coverage or pay any first party claim to such person.

(d) This act shall apply to all insurance applications, ratings, claims and other benefits made pursuant to any insurance policy.

Sec. 2. K.S.A. 1994 Supp. 40-2,118 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

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CONNAUGHT
LABORATORIES, INC.
A PASTEUR MÉRIEUX COMPANY

Senator Bond and Members of the Insurance Committee:

My name is Sanford Kaufman, Director of Public Health Sector Policy for Connaught Laboratories, Inc., a Pasteur Mérieux Company. On behalf of Connaught Laboratories, Inc. I wish to thank you for the opportunity to testify on behalf on Senate Bill 36, The Children's Immunization Reform Act.

Connaught Laboratories is a major developer and manufacturer of both pediatric and adult vaccines. We obviously have a strong commitment to research and development of vaccines in the U.S. But we have also been asked to provide expertise and support for activities that will help bolster immunization rates. As such we are deeply interested in working toward increasing age-appropriate immunization rates in both Kansas and the rest of the United States.

Inclusion of immunization in insurance coverage increases the likelihood children will get vaccines on time and where they usually receive their healthcare. The cost - benefit ratio for vaccines is widely acknowledged and, according the Centers For Disease Control and Prevention, can save $10-14 in treatment costs for every dollar spent on vaccines. This is one reason for the increased focus and attention being paid to expanding insurance coverage for immunization services. In 1994, three additional states enacted similar legislation, adding to the two other states with statues already in place. In addition, the Centers for Disease Control and Prevention lists expanded immunization insurance coverage among it's key policy objectives for 1995.

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Attachment #3

At a recent meeting sponsored by the new Sabin Foundation and attended by many experts in the field of immunization, including representatives of the National Vaccine Program Office, insurance coverage of immunizations emerged as a key issue needing attention and one which the group felt should become a primary objective. In addition, Partnership For Prevention, a national coalition of employers and providers supporting a range of scientific initiatives, supports coverage for immunizations.

The key role which will be played by Senate Bill 36 will be to eliminate one more barrier to the timely immunization of children. As noted in the social and financial impact statement, the net result of this legislation will be to get children immunized by age 2, when they are most vulnerable, instead of waiting until school entry when immunization is mandated by law. Therefore, as the impact statement concludes, the potential modest increase in insurance premiums is more than offset by the cost/benefit ratios vaccines represent.

We strongly support and urge the passage of Senate Bill 36.

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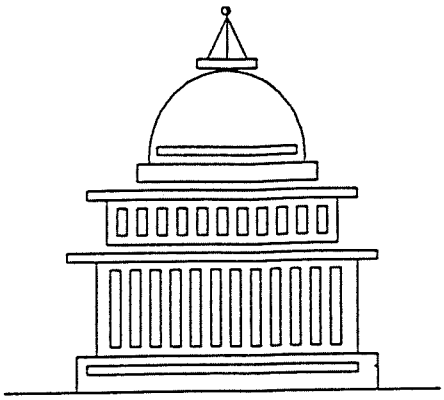

CHILDREN'S IMMUNIZATION REFORM ACT

SOCIAL AND FINANCIAL IMPACT STATEMENT

Prepared by

Mr. Richard Brock
Consultant/former Chief Assistant
Office of the Commissioner of Insurance
State of Kansas
January, 1995

Senate 4-4-1
1/19/95
Attachment #4

EXPLANATION
IMMUNIZATION REQUIREMENT

The attached legislative proposal amends K.S.A. 40-2,102. This is the statute which requires insurance policies to include coverage for newborn infants who are ill, injured, or born with a congenital defect or birth abnormality. By amending this particular statute the attached proposal is intended to: (1) add immunization benefits to the coverage already required to be made available for newly born children; (2) specify that such coverage requirement will apply from birth to 2 years of age; (3) statutorily identify the primary vaccines and dosages to be covered; and (4) provide flexibility for additional vaccines and dosages that may be prescribed by the Secretary of Health and Environment.

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LEGISLATIVE PROPOSAL
IMMUNIZATION REQUIREMENT

AN ACT relating to insurance accident and sickness insurance; immunizations; deductibles and coinsurance requirements prohibited; amending K.S.A. 40-2,102 and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE, State of Kansas:

Section 1. K.S.A. 40-1,102 is hereby amended to read as follows: 40-2,102. (a) All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity contracts issued by a profit or nonprofit corporation which provides coverage for a family member of the insured or subscriber shall, as to, such family members' coverage also provide that the health insurance benefits payable with respect to a: (1) newly born child of the insured or subscriber from the moment of birth; (2) newly born child adopted by the insured or subscriber from the moment of birth if a petition for adoption as provided in K.S.A. 59-2129 was filed within 31 days of the birth of the child; or (3) child adopted by the insured or subscriber from the date the petition for adoption as provided in K.S.A. 59-2129 was filed.

The coverage for newly born children shall consist of: (1) coverage of injury or sickness including the necessary care and

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treatment of medically diagnosed congenital defects and birth abnormalities and (2) routine and necessary immunizations for all newly born children of the insured or subscriber. For purposes of this subsection "routine and necessary immunizations" shall consist of at least 3 doses of vaccine against diphtheria, pertussis, tetanus and polio; 1 dose of vaccine against measles, mumps, and rubella; and such other vaccines and dosages as may be prescribed by the Secretary of Health and Environment. The required benefits shall apply to immunizations administered to each newly born child from birth to 2 years of age and shall not be subject to any deductible, copayment or, coinsurance, requirements.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or the filing of a petition for adoption and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth or the filing of the petition for adoption in order to have the coverage continue beyond the 31- day period. (b) All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity contracts issued by a profit or nonprofit corporation which provides coverage for a family member of the insured or subscriber, as to such family members' coverage, shall also offer

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an option whereby the health insurance benefits shall include delivery expenses at birth of the birth mother of a child adopted within 90 days of birth of such child by the insured or subscriber subject to the same limitations contained in such policy or contract applicable to the insured or subscriber. Such offer of an option regarding such delivery expense shall be made to the insured and, to the individual subscribers in the case of a group health insurance policy.

Section 2. K.S.A. 40-2,102 is hereby repealed.

Section 3. This act shall take effect and be in force from and after its publication in the statute book.

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SOCIAL and FINANCIAL IMPACT
LEGISLATIVE PROPOSAL
IMMUNIZATION REQUIREMENT

This social and financial impact statement conforms to the requirements of K.S.A. 40-2248 and provides the information required by K.S.A. 40-2249. Specifically, such statement accompanies and supports a legislative proposal which , if enacted, will make "first dollar" insurance coverage for "routine and necessary" immunizations available in health insurance policies covering Kansas children from birth to 2 years of age.

Since this proposal would, in fact, impose a requirement on the content of health insurance policies, it does fall within the traditional definition of a statutory mandate and is therefore subject to the provisions of the aforementioned statutes. It should be noted, however, that this so-called mandate is not directed toward the treatment of a particular disease or illness. Rather, it is directed toward immunizations, a long-standing, common and accepted means of preventing, as opposed to treating, disease. This is an important distinction because this statement will not seek to support a redirection of insurance benefits to a particular type of health condition or provider. In fact, since the state of Kansas already requires immunizations for all school-age children, it can and should be viewed as a reinforcement of an existing public policy.

SOCIAL IMPACT;

K.S.A. 40-2249 (a) (1) The extent to which the treatment or service is generally utilized by a significant portion of the population

Immunizations are, of course, widely utilized and are even required by law in certain instances. Therefore, whether or not they are widely used is not an issue. For purposes of the legislative proposal the question is more narrow in that it seeks to increase the delivery of immunizations before the age of 2. According to the latest available information more than half of all 2 year olds in the United States were immunized against diphtheria, tetanus, pertussis, measles, rubella and mumps in 1991. Specifically, 66.6% of the 2 year olds had received at least 3 doses of vaccine against diphtheria, tetanus and pertussis; 80.4% had been vaccinated for measles and, either alone or in some combination measles/rubella, measles/mumps or measles, mumps and rubella.[1]

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1. 1993 Statistical Abstract of the United States

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For the same year 52.2% of the 2 year olds had received 3 or more doses of polio vaccine[1] The same statistical breakdown is not available for Kansas. However, a retrospective review of immunization records of kindergarten children in the school year 1990-91 indicated that 48.7% of Kansas kindergartners had not been immunized by age 2 and more than 60% of children had not been fully immunized by age 2 in 22 Kansas counties. Corresponding numbers for the 1993-94 school year show some improvement but there were still 44.8% that had not been fully immunized by age 2 and less than 50% of the 2 year olds in 37 Kansas counties had been adequately immunized.[2] By any measure these are not acceptable numbers. Therefore, it seems clear that a public policy goal of 100% adherence to the immunization schedule recommended by The American Academy of Pediatrics (Exhibit One) or the Centers for Disease Control which recommends 4 doses of DTP, 3 polio doses and 1 dose of Measles/Mumps/Rubella before a child's second birthday is appropriate.

K.S.A. 40-2249(a) (2) The extent to which such insurance coverage is already generally available

Extensive data measuring this factor is not available. Kansas law requires all accident and sickness contracts to be filed with and approved by the Kansas Insurance Department prior to their sale to Kansas residents. The Insurance Department's files are not maintained in a way that segregates and/or accumulates different coverage components or contractual provisions. Thus specific information regarding the content of these filings is not readily available and a manual search would be so difficult and time consuming as to be prohibitive.

Notwithstanding the lack of extensive data, some measure of available insurance coverage for immunizations was obtained during the April 1994 phase of Kansas Operation Immunize 1993-94. Of 5677 respondents at the April 1994 sites, only 17.7% knew their private health plan covered immunizations; 54.7% knew it did not provide such coverage and 27.6% did not know.[3] At the same time, this data revealed that 70.4% of the 5677 respondents knew their child or children were covered by private health insurance.[4] From this limited data, it is apparent that

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1. 1993 Statistical Abstract of the United States

2. Immunization 2 Year Retrospective Survey; 4/11/94; KDHE Bureau of Disease Control

3. Kansas Operation Immunize; April 1994; KDHE

4. Ibid.

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few health insurance plans cover immunizations. This number would, no doubt, be even further reduced if the number of hea plans waiving or otherwise not applying deductibles, copayme. or coinsurance features as called for by the legislation had been ascertained. Support for this observation can also be found in a paper prepared for the American Academy of Pediatrics. In this paper it was reported that a survey of 1364 persons at 3 different sites conducted in the early 1980s found that only 30% of adults and 23% of children had preventive coverage in their health insurance plans.[1]

These numbers are not surprising. Insurance companies have not historically demonstrated great interest in using health insurance product design as a means of promoting healthy behavior. In fact, until the mid 1970s and the large scale advent of health maintenance organizations, insurers designed their products solely on the basis of the most marketable way to address the economic consequences of illness or injury. Even Kansas statutes, as do the statutes of most states, refer to "accident and sickness" insurance. It was not until the insurance community was faced with the competition produced by health maintenance organizations, preferred provider networks and other innovations designed to reduce the cost/use of medical care that society began to think of insurance as a means of reducing health care costs by promoting preventive services, wellness programs and other devices to enhance good health. Concurrent with this evolving concept the term "health insurance" began to have real meaning.

K.S.A. 40-2249 (a) (3) If coverage is not generally available the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment

A contention that the general nonavailability of insurance coverage for immunizations results in persons being unable to obtain immunizations cannot be supported. Public health facilities, Medicaid coverage, relatively low costs, projects like Kansas Operation Immunize 1993-94 and similar considerations argue persuasively that immunizations are widely available and generally accessible in Kansas.

Unfortunately, numerous authorities point to parental apathy, a lack of parental responsibility, inadequate information about the importance of early prevention and other similar factors as playing a very significant role in producing the inadequate immunization rates. On the other hand, 50% of the April 1994 participants in Kansas Operation Immunize indicated they chose that opportunity

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1. Premiums for Preventive Pediatric Care Recommended by the American Academy of Pediatrics; Actuarial Research Corporation; February 1991

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because of its "free/low cost status.[1] This simply confirm known fact about human nature but it also provides some empiri evidence that the lack of insurance coverage or the absence of first dollar coverage may contribute to low immunization rates.

K.S.A. 40-2249 (a) (4) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment

Generally speaking, if children are covered by a basic hospital, medical, surgical health insurance plan, the relatively low cost of immunizations would preclude the argument that the lack of insurance results in an unreasonable financial hardship. Yet, if the chain of potential circumstances is followed a bit further, it is quite plausible that the lack of insurance coverage can result in the lack of timely and adequate immunizations. If a preventable disease strikes, as can and does happen, financial hardship and great emotional distress can be the ultimate consequence.

K.S.A. 40-2249 (a) (5) The level of public demand for the treatment or service

If the level of public demand for early immunization opportunities was substantially higher, the numerous initiatives undertaken to increase immunization rates would not be necessary. Consequently, since the real focus of the legislation under review is to remove barriers that might result in a higher and earlier public demand for immunizations, the information sought by this statutory provision is not relevant.

K.S.A. 40-2249 (a) (6) The level of public demand for individual or group insurance coverage of the treatment or service

If the level of public demand for early immunizations is inadequate, it follows that the demand for insurance coverage within the context of this inquiry is also not high. Again, however, the objective of the proposed legislation is to raise the demand for early immunizations by removing some of the financial barriers that exist. Therefore, neither the lack of public demand for increased access to immunizations or the absence of a demonstrable interest in insurance coverage for immunizations should detract from the merits of the proposal.

1.Kansas Operation Immunize; April 1994; KDHE

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K.S.A. 40-2249 (a) (7) The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts

Information regarding this topic is unavailable but it can be presumed that any broadening of insurance coverage at no identifiable increase in cost would be welcomed.

K.S.A. 40-2249 (a) (8) The impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage

According to information reported by the Kansas Legislature's 1992 Special Committee on Children's Initiatives " early immunization for a variety of childhood diseases saves $10 in future medical costs for every dollar invested...."[1] The American Academy of Pediatrics cites various sources which proclaim a benefit/cost ratio of more than 14:1 for measles, mumps,rubella vaccine; 11:1 for pertussis vaccine given in combination with diphtheria and tetanus; and 10:1 for polio immunization. (Exhibit Two) These savings would almost all be realized in the form of indirect costs as defined in this statutory provision that would no longer be incurred. Such savings are the goal of the proposed legislation.

This finding makes it instructive to again remember that the legislative proposal deals with the prevention of disease not treatment. Moreover, the prevention produced by proper and timely immunization is a time tested and proven safe harbor against childhood diseases. Measles, mumps rubella, polio, pertussis and diphtheria are now rare in the United States. Nevertheless, they aren't unheard of and they aren't harmless. For example, information compiled by the Centers for Disease Control indicates that the incidence of measles rose to about 46,000 cases during the period 1989 through 1991 from a record low of 1,497 cases in 1983. Approximately 89 deaths were attributed to measles during this outbreak.[2]

All states, including Kansas, already recognize the value of immunization by requiring proof of immunization before allowing children to enter kindergarten or first grade. However, there is a problem with waiting until children are entering school to require immunization. In 1990, approximately half of reported

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1.Report on Kansas Legislative Interim Studies to the 1992 Legislature; Special Committee on Children's Initiatives; December 1991

2.Removing the Barriers; A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center; Brandeis University

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measles cases were among preschool children.[1] The medical literature agrees the diseases that immunizations protect against to be more severe in very young children. Consequently, both Centers for Disease Control and the American Academy of Pediatrics recommend an immunization schedule which begins at the age of 2 months and is completed by the age of 15 to 18 months with periodic and selected booster shots following at various ages thereafter. In 1979, the Surgeon General set a goal of 90% of 2 year olds immunized against common diseases by 1990.[2] Yet, as indicated by the results noted elsewhere in this statement, neither the U.S. or the State of Kansas have come close to reaching this goal. It seems obvious, therefore, that any initiative or requirement which would result in more children receiving necessary immunizations at an earlier age than they do now would produce significant reductions in the indirect costs, both economic and emotional, than could otherwise accrue.

FINANCIAL IMPACT;

K.S.A. 40-2249 (b) (1) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service

Requiring insurance contracts to include first dollar coverage for immunizations against childhood diseases cannot increase the cost of immunizations. Despite the unacceptable rate of immunizations by age 2, 97% of all children are immunized as required by the time they enter school.[3] Consequently, even though it would be a welcome result, enactment of the proposed legislation will probably not increase the number of children now immunized. Accordingly, enactment of the legislation cannot measurably change the units of the relevant vaccines that are sold or the provider costs associated with their administration.

K.S.A. 40-2249 (b) (2) The extent to which the proposed coverage might increase the use of the treatment or service

Since immunizations are already required for entry into Kansas schools, their use is assumed to be virtually universal. Therefore, enactment of the proposed legislation will not increase the

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1. Removing the Barriers; A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center; Brandeias University

2. Report on Kansas Legislative Interim Studies to the 1992 Legislature; Special Committee on Children's Initiatives; December 1991

3. Removing the Barriers: A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center; Brandeis University

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use of immunizations. It should and is intended to result in the earlier use of immunizations by at least some of the 45% Kansas children who are not now immunized by the age of 2 this factor will have no effect on the ultimate amount of vaccine administered or the number of vaccinations delivered.

K.S.A. 40-2249 (b) (3) The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service

In 1990 approximately half of reported measles cases were among preschool children.[1] In the 1980s a resurgence of mumps was attributed to a failure to immunize all susceptible persons.[2] Also in the 1980s, 10 large cases (>100 cases) of pertussis outbreaks occurred in the U.S.[3] Given these examples and these numbers, it is no wonder the 1991 legislative review found that early immunization saves $10 in future medical costs for every dollar invested.[4] Presumably, these reported savings already recognize the infectious nature of most childhood diseases but, if not, such savings would be multiplied several times.

Even without these numbers, the economic advantages of immunization are obvious. Smallpox, the virus which led to the development of the first successful vaccine almost 200 years ago [5] has become so rare that relatively recently scientists were reportedly discussing the wisdom of allowing the virus to become extinct. In 1952 there were 58,000 reported cases of polio but, because of immunization, this number shrank to 8 cases in 1986.[6] The value of immunization is not debatable and the legislative proposal under consideration is simply intended to encourage greater utilization of this resource by a segment of our preschool population that is still at risk.

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1. Removing the Barriers; A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center

2. Ibid.

3. Ibid.

4. Report on Kansas Legislative Interim Studies to the 1992 Legislature; December 1991

5. Fighting Disease, The Complete Guide to Natural Immune Power; Rodale Press; 1989

6. Life-Span Plus 900 Natural Techniques to Live Longer; Rodale Press; 1990

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K.S.A. 40-2249 (b) (4) The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders

Insurer reaction to a legislative proposal of this kind is difficult to predict but it should hae no measureable impact on insurance premiums.

Available information indicates that the total cost of immunizations that would be required by age 2 in the private sector is $525.[1] In view of the fact that the legislative requirement would affect only a very small segment of the insured population (birth to 2 years of age) and involves a very modest increase in individual claim costs even if no coverage whatsoever is currently provided, the impact should be statistically insignificant.

Notwithstanding the fact that this hypothesis seems reasonable when based solely on the anticipated impact of the proposed mandate, it may be somewhat misleading. While the proposal would affect only children from birth to 2 years of age, it is doubtful that insurers would restrict the coverage to these ages. As a result, the premium impact should probably be based on the assumption that insurers would incorporate immunization coverage for all dependents regardless of age. Consequently, the segment of the insured population affected by enactment of the legislation would be significantly larger. When applied to this population, the 1991 actuarial projection provided the American Academy of Pediatrics estimates that an additional premium of $1.83 per month per family would be necessary to cover immunizations in employer-sponsored commercial insurance plans.[2] Similar information is not available with respect to non-group plans but some information is available with respect to a much greater range of preventive services (Exhibit Three). It appears a charge of $4 to $5 additional premium per month is rather standard for non-group coverage that includes physical examinations, height, weight and blood pressure measurements, patient histories, vision and hearing screening, laboratory tests, accident prevention information and counseling in addition to immunizations. However, the Academy's actuaries were unable to test the reasonableness of these charges. They did note that 3 insurers in the survey indicated they made no additional charge for the preventive coverage and were able to verify the accuracy of this indication in one case but did not test the other two.

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1. Removing the Barriers; A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center; Brandeis University

2. Premiums for Preventive Pediatric Care Recommended by the American Academy of Pediatrics; Actuarial Research Corporation; February 1991

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Despite the possibility that some modest premium increases migl be attributed to enactment of the proposed legislation, it is imperative to recognize that the credible and authoritative cost/benefit ratios cited elsewhere in this statement obviously more than offset this impact.

K.S.A. 40-2249 (b) (5) The impact of this coverage on the total cost of health care

To the extent enactment of the subject legislation has a measurable effect on the total cost of health care, it will be favorable. As indicated earlier, the cost of immunizations is quite modest and is, in fact, already incurred by the time children enter school. Therefore, the only measurable effect the proposal could have on total health care costs would be the savings produced by the difference between the costs of immunization and the costs of treating those who contract the disease because they weren't immunized.

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EXHIBIT ON

Immunization Protects Children

Routine checkups at your doctor's office or local health clinic are the best way to keep children healthy.

By ensuring that your child gets immunized on schedule, you can provide the best available defense against dangerous childhood diseases. Childhood immunization provides protection against nine major diseases: hepatitis B, polio, measles, mumps, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), and *Haemophilus influenzae* type b. Is your child fully protected from these diseases?

The chart below includes immunization recommendations from the American Academy of Pediatrics. Check with your doctor or health clinic to find out whether your child needs additional booster shots or if other new vaccines

(continued on back)

Immunization Schedule Recommended by

American Academy of Pediatrics

	DTP[1]	Polio[2]	MMR	Hepatitis B[3]	Haemophilus[1]	Tetanus-Diphtheria
Birth				✔		
1-2 months				✔		
2 months	✔	✔			◆	
4 months	✔	✔			◆	
6 months	✔				◆	
6-18 months		✔		✔		
12-15 months			✔		◆	
15-18 months	●					
4-6 years	●	✔				
11-12 years			★	#		
14-16 years				#		✔

[1] The HbOC-DTP combination vaccine may be substituted for separate vaccinations for Haemophilus and DTP.

[2] Children in close contact with immunosuppressed individuals should receive inactivated polio vaccine.

[3] Infants of mothers who tested seropositive for hepatitis B surface antigen (HBsAg+) should receive hepatitis B immune globulin (HBIG) at or shortly after the first dose. These infants also will require a second hepatitis B vaccine dose at 1 month and a third hepatitis B vaccine injection at 6 months of age.

◆ Depends on which *Haemophilus influenzae* type b vaccine was given previously.

● For the fourth and fifth dose, the acellular (DTaP) pertussis vaccine may be substituted for the DTP vaccine.

★ Except where public health authorities require otherwise.

For children who did not get this vaccination in the first 18 months of life, the hepatitis B vaccine series of three shots should be given at preadolescence or at adolescence.

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have been recommended. For the best possible protection against diphtheria, tetanus, and pertussis, your child needs a series of five shots of the combination diphtheria-tetanus-pertussis (DTP) vaccine. These doses should be given at 2, 4, 6, 15 to 18 months of age, and a final booster dose given before school entry (4 to 6 years). For the fourth and fifth dose, the acellular (DTaP) vaccine may be substituted for the DTP vaccine. The DTP vaccine is also available as a combination vaccine with Hib. This combination vaccine can be used in infants scheduled to receive separate injections of DTP and Hib.

For protection against polio, your child needs the series of four oral polio vaccine doses at: 2, 4, 6 to 18 months, and a final dose before school entry at 4 to 6 years of age.

To be completely protected against hepatitis B, your child needs to be vaccinated with a series of three hepatitis B virus (HBV) vaccine shots: at birth, at 1 to 2 months, and again at 6 to 18 months of age. For children who did not get this vaccination in the first 18 months of life, the hepatitis B vaccine series of three shots should be given at preadolescence or at adolescence.

Several vaccines are available for protection against *Haemophilus influenzae* type b. The Academy recommends that your child receive doses at 2, 4, and possibly 6 months of age, with a final dose at 12 to 15 months depending on which vaccine is used. If your child is late getting the first Hib conjugate dose, the total number of doses received may differ from this AAP schedule.

At 12 to 15 months, your child should have a combination shot against measles, mumps, and rubella (MMR). A second MMR vaccination, primarily to boost measles protection, should be given to children 11 to 12 years or older who have not had measles. If there is a measles outbreak in your community or if you live in a high-risk area, the MMR shots may be given on a different schedule.

If you don't have a pediatrician, call your local public health department. Public health clinics usually have supplies of vaccine and may give shots free.

American
Academy of
Pediatrics

IS5081

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Immunizations have repeatedly been demonstrated as effective in reducing the incidence of childhood diseases. Today, children receive routine vaccinations against eight diseases: diphtheria, tetanus, pertussis (whooping cough), polio, measles, mumps, rubella (German measles), and serious infections caused by *Haemophilus influenzae* type b (Hib).

- The benefit-cost ratio of measles-mumps-rubella vaccine is more than 14:1.[1]
- A 20-year study of measles vaccination revealed cost savings totaling more than $5 billion.[2]
- The benefit-cost ratio of pertussis vaccine given in combination with diphtheria and tetanus is 11:1.[3]
- For polio immunization, the benefit-cost ratio is 10:1.[4]
- For the 18-month Hib vaccine, vaccination of 60% of all children would yield a savings of $207 million.[5,*]
- The benefit-cost ratio for the Hib vaccine given at 18 months is about 3.6:1.[5,*]

1. White CC, Koplan JP, Orenstein WA. Benefits, risks and costs of immunization for measles, mumps and rubella. *Am J Public Health.* 1985;75(7):739-744
2. Bloch AB, Orenstein WA, Stetler HC. Health impact of measles vaccination in the United States. *Pediatrics.* 1985;76(4):524-532
3. Hinman AR, Koplan JP. Pertussis and pertussis vaccine, reanalysis of benefits, risks, and costs. *JAMA.* 1984;251(23): 3109-3113
4. Fudenberg HH. Fiscal returns of biomedical research. *J Invest Dermatol.* 1973;61: 321-329
5. Hay JW, Daum RS. Cost-benefit analysis of *Haemophilus influenzae* type b prevention: conjugate vaccination at eighteen months of age. *Pediatr Infect Dis.* 1990;9(4):246-252

* In October 1990, the recommended schedule for the *Haemophilus influenzae* type b conjugate vaccine was changed to 2, 4, and 6 months with a booster at 15 months. Since such a high percentage of infections caused by the Hib bacteria occur in the first 12 months of life, it is anticipated that the revised schedule will result in even greater savings.

American Academy of Pediatrics

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Table 7

Non-group Individual Health Insurance
Premiums for Child Supervision

Insurance Company	Product Name	State	Charge for Child Supervision Services Per Child Per Month	Effective Date
American Association of Lutherans	Total Med II	FL	$4.17	Jan 1989 to present
Benefit Trust	Telemed	AR, FL, MA MN, RI	$5.00	Current ($4 in 1989)
Central States Health and Life	Individual Major Medical	Fl	$5.00	Dec 1989 to present
Pyramid Life	G91	FL	$5.00	Current
Pyramid Life	G91	AR	$5.58	Current
Pyramid Life	G91	MN	$4.58	Current
Washington National	Classic Choice	FL	$7.00	Jan 1990 to present
Time	24 Karat	FL	no additional charge	
First National Life	Major Medical	FL	no separate charge	
Metropolitan Life	Major Medical	FL	no separate charge	

EXHIBIT THREE

PARTNERSHIP FOR CHILDREN

1055 Broadway, Suite 170
Kansas City, Missouri 64105

(816) 842-7643
Fax • (816) 842-7907

IMMUNIZATION FACT SHEET

- Diseases that are easy to prevent and expensive to treat make a strong case for the importance of immunizations. The Centers for Disease Control and Prevention estimate that every dollar spent on immunization saves $10 in treatment; therefore, it makes economic and emotional sense to get children immunized as early as possible.

- Nine of the most serious childhood diseases, including polio, measles, and whooping cough, can be prevented through timely immunizations. These diseases can cause severe illness, crippling physical and mental disabilities, and even death.

- According to public health authorities, two years of age is the optimal completion date for immunizations for greatest effectiveness. Epidemics spread quickly among those age two and younger, and diseases like whooping cough and measles can kill the very young. To prevent outbreaks of vaccine-preventable diseases, and protect all children, it is necessary to immunize children at the earliest appropriate age.

- In 1993 in Kansas, only 57% of our kindergartners were fully immunized by age two. There was no appreciable change in the immunization rate for 1993 as compared to the base years 1989-1990, and 1992.

- In 1993 in approximately one-third of Kansas counties **less than half** of the two year olds were fully immunized.

- In 1993 **no Kansas county** reached the national goal for the year 2000, which is to fully immunize 90 percent of all two year olds.

- In Finney, Graham, Neosho, Woodson, and Wyandotte counties, **less than one-third** of our two year olds were fully immunized.

Senate 7141
1/19/95

KSNA
the voice of Nursing in Kansas

KSNA & You
A Powerful Match

FOR MORE INFORMATION CONTACT:
Terri Roberts JD, RN
Executive Director
Kansas State Nurses Association
700 SW Jackson, Suite 601
Topeka, KS 66603-3731
913-233-8638
January 19, 1995

S.B. 36 Health Insurance Coverage for Childhood Immunizations, Birth-2 Years

Chairperson Bond and members of the Senate Financial Institutions and Insurance, my name is Mary Kopp M.N. and I represent the Kansas State Nurses Association. I am here today as a proponent for Senate Bill 36.

I would like to preface my remarks by saying that the recommended amendment to K.S.A. 40-2, 102 is an affordable, supportive approach towards preventing the senseless spread of childhood diseases and subsequent complications, life-long disabilities or possible deaths. For every $1.00 spent on vaccine, $14.00 are saved on complications. A typical hospitalization due to Measles complications averages $3600. The Measles outbreak in 1989-1991 in which there were 55,000 diagnosed cases, 11,000 hospitalizations, and 130 deaths signaled health problems in our environment.

As you well know, Kansas 2-year olds are struggling to maintain a 50-60% overall immunization compliance rate. Our goal is 90% by 1996. According to the Children's Defense Fund Report, this is equal if not below the national average of 55.3%, depending on the county. Childhood immunization rates remain low, affected by one of the issues that brings us here today, COST. Parental surveys indicate that cost remains a barrier in obtaining immunizations.

In our multi-health care delivery system in America, an individual can obtain immunizations from approximately 5 different providers. Those being private physician offices, public health centers, community, migrant and homeless centers. In Kansas the public/private service delivery is split 35% private office and 65% public centers. This is particularly significant to the underinsured individuals of which this bill is addressing.

Under the new Federal entitlement program, Vaccine for Children, which became effective October 1, 1994, all underinsured individuals must obtain their immunizations at Federal Qualified Health Centers (FQHC). This has added an additional barrier since

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1/19/95
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there are only 6-8 FQHCs in Kansas. Annually all states apply for federal grant immunization monies. This is a state by state initiative. It is known as Title 317. This money can be used for underinsured individuals but the money does run out. If and when that occurs this additional barrier of referring underinsured to FQHCs is very real. Since the Vaccine for Children program just began, it is too early to determine cost coverage through 317. Despite Congress' intentions to decrease barriers more might be created.

It is important that infants obtain age appropriate immunizations. For example Haemophilus Influenzae type b of Hib, a bacteria, causes an array of infectious diseases. The most serious cases, being Meningitis and infection of the joints and heart membrane, occur between 6 months to 1 year. Hib strikes about 1 in every 200 children in the U.S. before their fifth birthday. Following age 5, the morbidity rates drop significantly. In fact, health officials do not consider it necessary to vaccinate children over 5. That is why vaccinating on time with the barrier of COST eliminated is so important.

I'll close with this metaphor--what does a case of Measles and a miner's dead canary have in common? Both signal a problem in the environment. As the miner's canary lives, so do our children, if we are mindful and supportive of the health environment in which we live.

Thank you.

b:\wp51\legis95\yellow\sb36\la

1/19/95
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Number of reported cases of diseases preventable by routine childhood vaccination—United States, September 1994 and January-September, 1993-1994*

Disease	No. Cases Sept. 1994	Total cases January - September 1993	Total cases January - September 1994	No. cases among children aged < 5 years January - September† 1993	No. cases among children aged < 5 years January - September† 1994
Congenital rubella syndrome (CRS)	1	5	3	4	2
Diphtheria	0	0	1	0	1
Haemophilus influenzae§	86	958	874	292	234
Hepatitis B¶	1,057	9,437	8,794	89	91
Measles	30	269	844	102	194
Mumps	108	1,244	1,068	209	170
Pertussis	339	4,366	2,553	2,598	1,457
Poliomyelitis, paralytic**	0	3	1	1	1
Rubella	6	165	210	25	21
Tetanus	4	33	26	0	0

* Data for 1993 are final and for 1994, provisional.

†For 1993 and 1994, age data were available for 90% or more of cases, except for 1993 age data for congenital rubella syndrome (CRS) and tetanus, which were available for 80% and 88%of cases.

§Invasive *H. Influenzae* disease serotype is not routinely reported to the National Notifiable Diseases Surveillance System.

¶Because most hepatitis B virus infections among infants and children aged less than 5 years are asymptomatic (although likely to become chronic), acute disease surveillance does not reflect the incidence of this problem in this age group or the effectiveness of hepatitis B vaccination in infants.

** One case with onset in 1994 has been confirmed; this case was vaccine associated. In 1993, 3 of 10 suspected cases were confirmed. Two of the confirmed cases of 1993 were vaccine-associated, and one was classified as imported.

**Immunization Action News. Department of Health and Human Services, Centers for Disease Control and Prevention. 1:12. Page 3.

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6-3

H U M A N A

Government Relations Department
10450 Holmes, Suite 330
Kansas City, MO 64131-3471
816-941-5381
FAX 816-942-6782

SENATE BILL 36
IMMUNIZATION OF INFANTS

I represent Humana Health Care Plans and am here to express support for Senate Bill 36, requiring health care protection plans to provide certain immunization protection for children under the age of 2.

Humana has more than 22,000 members in Kansas, 1.8 million members nationally. More than half these are in Health Maintenance Organizations.

Senate Bill 36 is a mandate to provide services. Humana along with almost all other managed care providers, strongly opposes the principal of government mandates because we consider them not only ineffective but usually counterproductive. Let me make it clear that our support of SB 36 does not represent a change in our opinion, but rather a rare exception because of unusual circumstances.

As a matter of fact, Humana's HMOs provide immunization to children as a routine benefit in our contracts. We do it primarily because we consider it part of our responsibility to maintain health, rather than simply to try to cure disease. We believe it is also cost effective.

HMOs - prepaid group practices - were originally a product of consumer demand. They were created to provide comprehensive services under a responsible, organized system of delivery, at a reasonable and affordable cost. The concept was - and still is - to control costs by using all possible preventive practices, assure the proper course of treatment, and remove the incentive to overtreat.

We agree that lack of immunization can be a time bomb in any community, and are ready to cooperate to reduce the risk. In so doing, we also recognize that we are protecting ourselves against the extremely high cost of treatment of the aftereffects of some of the infectious diseases. It is a principle that correct preventive care, properly delivered, is a cost saver.

One additional comment: We in managed care feel about mandates, including so-called "any willing provider" legislation much as you do about Federal mandates on state expenditures. We have tried to explain the evils of mandates in almost the identical terms you use: that in restricting our independence of action you inevitably hinder our ability to do our job.

Meyer L. Goldman,
Government Relations.

Senate H&I
1/19/95
Attachment #7

State of Kansas

Bill Graves Governor

Department of Health and Environment
Bob J. Mead, Acting Secretary

Testimony presented to

Senate Committee on Financial Institutions and Insurance

by

The Kansas Department of Health and Environment

Senate Bill 36

The proposed Senate Bill 36 amends K.S.A. 40-2,102. This statute requires insurance policies to include coverage for newborn infants who are ill, injured, or born with a congenital defect or birth abnormality. By amending this particular statute, the proposal is intended to: (1) add immunization benefits to the coverage already required to be made available for newly born children; (2) specify that such coverage requirement will apply from birth to 2 years of age; (3) statutorily identify the primary vaccines and dosages to be covered; and (4) provide flexibility for additional vaccines and dosages that may be prescribed by the Secretary of Health and Environment.

First dollar vaccine coverage would provide additional vaccine accessibility by providing vaccine to children who are insured, without the parental concern of meeting a deductible/coinsurance or being referred to a local health department. This should encourage parents to get their children's immunizations from their children's private physicians and reduce the number of children going to local health departments.

A joint effort between the public and private sectors is necessary for Kansas to meet its Year 2000 Immunization goals. This bill provides for more opportunities to reach children with age appropriate immunizations.

The Kansas Department of Health and Environment supports SB 36.

Testimony presented by: Steven R. Potsic, M.D., M.P.H.
Director of Health
Kansas Department of Health and Environment
January 19, 1995

Senate 4/81
1/19/95

Office of the Director of Health
900 SW Jackson, Rm 620, Topeka, KS 66612-1290

Telephone: (913) 296-1086
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Attachment # 8

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

January 19, 1995

To: Senate Financial Institutions and Insurance Committee

From: C. Wheelen, KMS Director of Public Affairs

Subject: Senate Bill 36

The Kansas Medical Society supports the provisions of SB36 requiring first dollar coverage of early childhood immunizations. We believe it is one of the ways that we can improve rates of age appropriate immunization among Kansas children.

Physicians are increasingly aware that the cost of vaccine products creates a hardship for parents. Consequently, some physicians refer the parents to local public health clinics where they can have their children immunized at a much lower cost. This is possible because public health agencies are allowed to purchase vaccines at a significantly lower price than private physicians must pay. The physicians who refer the parents to local public health clinics believe they are avoiding unnecessary health care expenditures. Unfortunately, this may result in delayed immunization of the children.

Conversely, some parents take their children to public health departments for immunizations but do not take them to a physician for periodic well baby checkups. This is also unfortunate because the opportunity for early detection of disease or a disabling condition may be lost. Under either scenario, it is the child who is at risk and could suffer long-term consequences.

We are somewhat disappointed that the bill requires coverage of immunizations only until the child reaches age two. We would prefer that the coverage be extended through age five in order to cover the cost of vaccines that are given in a series at periodic intervals, and to allow those parents who failed to get their children immunized prior to age three to catch up with the schedules through age five. We urge your favorable consideration of such an amendment.

We believe that passage of SB36 would make it possible for more children to be immunized at the physician's office or medical clinic in conjunction with other pediatric care. We think that this will increase the ratio of children who are immunized at appropriate ages. It is for these reasons that we request your favorable action. Thank you for considering our comments.

Senate 7/41
1/19/95
Attachment #9

Kansas Action for Children, Inc.
Where Kansas Kids Count!

715 SW 10th Suite 215
PO Box 463
Topeka, Kansas 66601-0463
Phone: (913) 232-0550
Fax: (913) 232-0699

Johannah Bryant
Executive Director

Testimony to the
Senate Financial Institutions and Insurance Committee
by
Kansas Action for Children
January 19, 1995

The newly released *1995 Kansas Kids Count Data Book*, which is a project of Kansas Action for Children, contains some good news about immunizations for young children.

The good news is that we are making progress in fully immunizing children by age 2. Consider:

1990 - 51.7% of kindergartners fully immunized by age 2
1992 - 53% of kindergartners fully immunized by age 2
1993 - 57% of kindergartners fully immunized by age 2

This steady progress does not include the full impact of Operation Immunize, which we will begin to see in the *1996 Kansas Kids Count Data Book*.

We all want to continue the momentum Kansas has created toward reaching 90% of children fully immunized by age 2. Our state has already received national recognition for its efforts.

Amending K.S.A. 40-2, 102 in the manner proposed by SB 36 can bring the state another tool to improve our performance on immunizations. We strongly encourage the state to pass SB 36 and create another method to encourage all children to be fully immunized by age 2.

Senate FI&I
1/19/95
Attachment # 10

Patrick J. Hurley & Company
GOVERNMENT RELATIONS

January 19, 1995

Senator Dick Bond
Chairman
Senate Committee on Financial
Institutions and Insurance
128-S - State Capitol
Topeka, Kansas 66612

Dear Senator Bond,

I am hereby submitting on behalf of the Kansas Academy of Family Physicians a letter from their president, Dr. Richard L. Watson, expressing their members support for the passage of SB 36.

Dr. Watson was unable to appear to present this testimony at the hearing on January 19, and would request that it be distributed to all the members of the Committee.

If there are questions regarding the position of the Kansas Academy of Family Physicians, I would be happy to communicate them to Dr. Watson for an appropriate response.

Thank you for your consideration in this matter.

Sincerely,

Patrick J. Hurley

PJH/hma

Encl.

800 Jackson
Suite 1120
Topeka, KS 66612
913-235-0220
Fax 913-435-3390

Senate 7+T
1/19/95
Attachment #11

Kansas Academy of Family Physicians

1999 N. Amidon, Suite 300, Wichita, KS. 67203-2124
Phone (316) 832-1408, Fax (316) 832-0079

TO: Committee on Financial Institutions & Insurance

FROM: Kansas Academy of Family Physicians (KAFP)
Richard L. Watson, M.D., President Richard L. Watson MD

DATE: Jan. 19, 1995

RE: Senate Bill No. 36, An Act relating to accident and health insurance; immunizations, amending K.S.A. 40-2;102 and repealing the existing section.

The Kansas Academy of Family Physicians supports adequate, timely immunizations of all children. One of the barriers is cost, if a family does not have immunizations covered through their insurance. This bill would help bridge the gap for families who haven't had immunizations covered through insurance. We support it, and hope it will help increase the timely immunizations of Kansas children.

Representing the largest medical specialty group in Kansas

FHH 1/19/95

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