Approved: Robert Tomlinson
Date April 30, 1999

MINUTES OF THE .

The meeting was called to order by Chairperson Bob Tomlinson at 3:30 p.m. on March 4, 1999 in Room 519-S of the Capitol.

All members were present except: Rep. Vining, Toelkes

Committee staff present:
Bill Wolff, Research
Ken Wilke, Revisor
Mary Best, Secretary

Conferees appearing before the committee:
Carol Hands-Keedy, Kansas Association for the Blind and Visually Impaired, Inc.
Mary Ellen Wright, Assisted Technology for Kansas
Marcelle Shrake
Connie Broadbent
Jennifer Schwartz
Dot Nary
Nora Manier
Shaun Spotted Horse
Nancy Ruoff
Sherrie Diel-Kansas Advocacy & Protective Services, Inc.
Tom Laing, InterHab
Joyce Byrd, Shawnee county Advocacy Council on Aging
Larrie Ann Brown, Kansas Association of Health Plans
Terry Leatherman, Kansas Chamber of Commerce & Industry
Brad Smoot, Blue Cross/Blue Shield
Dave Hanson, American Family Life Assurance Company of Columbus

Others attending: See Attached Conferees List

The Chair called the meeting to order. The meeting was moved from the regular meeting room (527-S) to room 519-S, to accommodate the conferees and families in wheelchairs, and those using other support equipment. The Chair opened the discussions to the public .

HB 2097: Mandated insurance coverage for durable medical equipment.

The Fiscal Note is (Attachment #1) attached hereto and incorporated into the Minutes by reference. The bill sets out the amount of $10,000. Per individual per year for such medical equipment as listed in the bill. These must be prescribed by physician.

Carol Hands-Keedy, Kansas Association for Blind & Visual Impaired, gave Proponent Testimony to the committee. A copy of her testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference.

Mary Ellen Wright, Assisted Technology for Kansas, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference.

Marcelle Shrake, gave Personal Interest Testimony, to the committee. A copy of the testimony is (Attachment #4) attached hereto and incorporated into the Minutes by reference.

Ms. Connie Broadbent, gave Proponent Testimony, to the committee. A copy of the testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference.

Ms. Jennifer Schwartz, gave Proponent Testimony, to the committee. A copy of the testimony is (Attachment #6) attached hereto and incorporated into the Minutes by reference.

Ms. Dot Nary, gave Proponent Testimony, to the committee. A copy of the testimony is (Attachment #7) is attached hereto and incorporated into the Minutes by reference.

Ms. Nora Manier, gave Proponent Testimony, to the committee. A copy of the testimony is (Attachment #8) attached hereto and incorporated into the Minutes by reference.

Mr. Shaun Spotted Horse gave Proponent Testimony, to the committee. A copy of the testimony is (Attachment #9) attached hereto and incorporated into the Minutes by reference.

Mrs. Nancy Ruoff, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #10) attached hereto and incorporated into the Minutes by reference.

Ms. Sherrie Diel, Kansas Advocacy and Protective Services, Inc., gave Proponent Testimony. to the committee. A copy of the testimony is (Attachment #11) attached hereto and incorporated into the Minutes by reference.

Mr. Tom Laing, InterHab, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #12) attached hereto and incorporated into the Minutes by reference.

Mr. Tom Laing also presented written Proponent Testimony for Mr. Patrick Terick, The Cerebral Palsy Research Foundation of Kansas, Inc. A copy of the testimony is (Attachment #13) attached hereto and incorporated into the Minutes by reference.

Ms. Joyce Byrd, Shawnee County Advocacy Council on Aging, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #14) attached hereto and incorporated into the Minutes by reference.

Ms. Larrie Ann Brown, Kansas Association of Health Plans, gave Opponent Testimony t the committee. A copy of the written testimony is (Attachment #15) attached hereto and incorporated into the Minutes by reference.

Mr. Terry Leatherman, Kansas Chamber of Commerce and Industry, gave Opponent Testimony to the committee. A copy of the written testimony is (Attachment #16) attached hereto and incorporated onto the Minutes by reference.

Mr. Brad Smoot, Blue Cross/Blue Shield, gave Opponent Testimony to the committee. A copy of the written testimony is (Attachment #17) attached hereto and incorporated into the Minutes by reference.

Mr. Dave Hanson, American Family Life Assurance Company of Columbia, gave Opponent Testimony to the committee. A copy of the written testimony is(Attachment #18) attached hereto and incorporated into the Minutes by reference.

The following Conferees offered written Proponent Testimony only and copies of such testimony are (Attachments #19 to 32) attached hereto and incorporated into the Minutes by reference. Mr. Steve Richardson, Mark Green, Roger Harsh, Michael Byington, Envision Governmental Affairs Office, Wayne Franklin, Commission On Disability Concerns, Ms. Donna Stevenson, Community Action, Bonnie Pennie, Families Together, Inc.,Jan Naegele, Brenda Eddy, Shannon Jones, Statewide Independent Living Council of Kansas, Barbara Wetzler, Wheels for Freedom, Gina McDonald, Kansas Association of Centers for Independent Living, and Steve and Kristin Cooper. Mr. James Schwartz, Kansas Employer Coalition on Health, Inc., submitted Opponent Testimony.

The Chair called for any further discussions or conferee testimony on the bill. As none was offered the Chair closed further discussions on the bill and adjourned the meeting. The time was 5:55 p.m.

The next committee meeting will be held March 9, 1999.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: 3/4/99

NAME	REPRESENTING
Sharon Huffman	KCDC - KDHR
Sheila Simmons	Assistive Tech for Kansans
Carole Hands	Kansas Association Blind & Visually [illegible]
Linda L. Hall	Assistive Technology for Kansans
Joyce E Byrd	Shawnee Cnty Advocacy Council on Aging
Donna J. Kidd	Shawnee County Advocacy Council on Aging
Wesley Marshall	InterHab
Pat Morris	KAIA
Stephanie Guber	Kansas Dept. on Aging
Shaun Spotted horse	self
Connie Broadbent	Andrew Sterling - son
Kevin Davis	Am. Family Ins.
Tom Laing	InterHab
Shannon McWilliams	Independence Inc
Joan Murphy	AMS - Medicaid, Topeka
Steve Richardson	TILRC
Beatrice Kroke	Public
Keith Kroke	Public
Nancy [illegible]	Parent + SBOT

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: 3/4/99

NAME	REPRESENTING
Marcelle Shrake	Parent & SBOT
Jennifer Schwartz	Parent
Dot Nary	~~B~~ Person w. a Disability
Jessica Schwartz	" " " "
Josie Torrez - Ks Council on	Developmental Disabilities
Mary Ellen O'Brien Wright	Assis. Tech. for Kansans
Pamela Cress	Assistive Technology for Kansans
Richard Gutierrez	Independence, Inc.
Sherry Diel	KS Advocacy & Protective Services, Inc.
Stacy Soldan	Columbia / HCA
Sara Sack	Assistive Technology for Kansans
Donna Stevenson	Community Action, Inc.
Jim Johnson	Parent
Marjorie Keating	Kansas Ins. Dept.

Tom Thompson.
236-9161

Vote no B..

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1575
(785) 296-2436
FAX (785) 296-0231

Bill Graves
Governor

Duane A. Goossen
Director

March 3, 1999

The Honorable Bob Tomlinson, Chairperson
House Committee on Insurance
Statehouse, Room 112-S
Topeka, Kansas 66612

Dear Representative Tomlinson:

SUBJECT: Fiscal Note for HB 2097 by House Committee on Insurance

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2097 is respectfully submitted to your committee.

HB 2097 would be new law, providing that after July 1, 1998, all health insurance policies provide coverage for durable medical equipment. The policies would have to provide coverage of at least $10,000 per individual per year for such items as powered wheelchairs, scooters, augmentative communication devices, and low vision devices. The bill provides that these items be covered when prescribed by a physician.

The bill could have a fiscal impact on the state because it is a health insurer for state employees. This cost could be between $1,873,000 and $2,497,000, of which $917,770 to $1,223,530 could be from the State General Fund. The State Employees Health Care Administration, which administers the health insurance program for state employees, indicates that it currently covers the cost of durable equipment up to maximums of between $2,000 and $2,500 per year per person. Therefore, the bill would increase the maximum coverage. The increase in the maximum coverage according to the agency could require an increase in costs of between 1.5 percent ($1,873,000) and 2.0 percent ($2,497,000) for FY 2000 for the state employees health plan.

The bill could also increase the costs for local governments and other citizens of the state who have either group or individual health insurance policies. The amount of the increase would depend on how much coverage the local governments and individuals currently are provided through their existing health insurance for durable medical equipment compared to the amount

ATTACHMENT #1
House Committee on Insurance
March 4, 1999

the policies would provide because of the new mandate. Any increase in state expenditures because of this act would be in addition to the amounts included in *The FY 2000 Governor's Budget Report*.

Sincerely,

Duane A Goossen

Duane A. Goossen
Director of the Budget

cc: Paul Davis, Insurance Department
Pat Higgins, Department of Administration

Kansas Association for the Blind
and Visually Impaired, Inc.

AN AFFILIATE
OF THE
AMERICAN COUNCIL
OF THE BLIND

TO: the House Insurance Committee

FROM: Carole Hands-Keedy, Lobbyist

SUBJECT Support for House Bill 2097

The Kansas Association for the Blind and Visually Impaired, Inc. (KABVI), represents a population of individuals who, for the most part, have no coverage for durable medical equipment. Items which help people who are blind or who have low vision read, for example, are not currently covered under almost all third party insurance. Part of the problem is that such equipment is often not even defined as durable medical equipment.

KABVI supports the definition of "durable medical equipment" contained in House Bill 2097 because at least blind and low

ATTACHMENT #2
HOUSE COMMITTEE ON INSURANCE
MARCH 4, 1999

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Post Office Box 292 / Topeka, Kansas 66601

vision people would be in the parameters of having the items we use to regain function defined as being a type of durable medical equipment.

Having vision loss is a medical condition. Having equipment available which restores ability to do things which normally require vision is no different than providing a wheelchair to restore the ability of moving from place to place for someone who can not do so without the assistance provided through the chair.

The equipment my peers and I use because we are legally or totally blind does not come in pill form. We often do not attach it on the inside or outside of our bodies. Yet just as Dilantin may prevent someone from having a seizure, the use of low vision aids keeps me from being a non-reader.

No entitlement program provides the type of equipment people who are blind or low vision use to live and work independently. Many of our KABVI members therefore live in the last century in that they simply do not have equipment which makes reading possible or which restores other functions lost with the loss of vision, this is not because there is a lack of equipment which can help. It is because many of the things are beyond the incomes of those in need, and even where our members are paying for very credible health insurance policies, the policies do not cover anything which helps gain functional ability.

Assistive
Technology
For
Kansans

A Project
Coordinated by the
University of Kansas
At Parsons

For Statewide
Information and
Referral Phone
800-526-3648
(Voice & TTY)

Testimony Presented before the House Committee On Insurance
Regarding House Bill 2097
Mary Ellen O'Brien Wright
Assistive Technology for Kansans
March 4, 1999

I am Mary Ellen O'Brien Wright with Assistive Technology for Kansans and I am here today in support of House Bill 2097, which would establish a minimum that health insurance companies must pay annually per individual for Durable Medical Equipment (DME), define DME more broadly, and provide power equipment, when appropriate.

The need for DME on the part of someone with a disability is essential, not a mere convenience. Some of the reasons children and adults use DME include increased functioning, preventing further deterioration, and/or replacing or alleviating the malfunction of a body part. Few, if any of us, would choose to use DME in the absence of an illness, injury or permanent disability. Private insurance is one source of funding for DME, a source for which individuals pay for themselves, through their employer, or a combination of both, by paying health insurance premiums. This is done in the hope of having adequate health care coverage in the event it is needed. Adults with disabilities and families with children with disabilities have brought it to our attention that adequate DME coverage is not always available through private health insurance.

Some health insurance companies avoid paying for DME by establishing annual policy limits per individual that are so low that it may not even cover one piece of equipment. Annual policy limits vary, but an average figure is $1,000. The cost of DME needed by children and adults with severe disabilities or chronic illness may easily exceed these policy limits. Insurance companies may refuse to provide certain equipment even in the presence of a medical condition and when medically appropriate, by defining "medical need" so strictly that minimal DME is covered, or by stating that certain items are "not covered".

When DME is inadequately covered by health insurance companies assistance is frequently sought from taxpayer supported programs such as Medicaid, Medicare, Vocational Rehabilitation or non-profit organizations. This shifts the cost of funding DME onto public programs rather than for-profit health insurance companies. Inadequate DME coverage can also lead to increased physical deterioration and dependence. Debilitation and lack of independence places a heavier burden on caregivers, resulting in institutionalization, particularly nursing home placements. Once again, the financial burden falls on the public sector. And the cost of nursing home placement is much higher than the cost of the DME necessary to maintain and/or improve functioning and independence.

The fiscal note for this bill prepared by the staff of the Insurance Commissioners Office must concern you. The note is based on the rather broad definition of DME included in this bill. The intent of this definition was not to obtain a Whirlpool/Jacuzzi or similar items, but to provide adequate insurance coverage for essential equipment such as power wheelchairs, augmentative communications devices, hearing aids, low vision devices, and bath chairs. Given that the true intent of this bill is to ensure that

ATTACHMENT #3
HOUSE COMMITTEE ON INSURANCE
MARCH 4, 1999
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essential equipment is covered, *Assistive Technology for Kansans* would be willing to review this definition with representatives of the insurance industry to address their concerns about this definition and develop a definition that would meet their need for cost containment as well as our need for adequate coverage.

The insurance industry representatives opposing this bill last winter and summer objected to it for a number of reasons, and I would like to briefly address some of their objections.

- **This is "Cadillac" coverage. As you hear people testify today, I think you will see that they are not requesting a Cadillac, but just the equipment necessary to address the functional limitations imposed by their medical condition. Again, few if any of us would choose to use such equipment if not absolutely needed.**
- **Health insurance is not a "social service" program. With this we are in agreement. We recognize that the health insurance industry is not a social service program but a "for profit" industry. Their profits, however, should not be made at the expense of state and federal supported social service programs, and ultimately, taxpayers.**
- **This bill would only apply to 35% of people who have health insurance coverage. This would be 35% more people adequately covered than are presently, and we can accept that.**
- **The cost of this bill would be too high. As stated earlier, we are certainly willing to address the DME definition in this bill in the interest of cost containment. However, it should be pointed out that in some situations the provision of appropriate equipment saves money by avoiding prolonged hospitalization or nursing facility stays and/or expensive treatments.**

Last summer, the Special Committee On Financial Institutions and Insurance recommended the development and passage of House Bill 2005, a bill which require that all mandates must first apply to the state health care system before being passed on to other insurers. Given that cost appears to be a major issue related to DME, the passage of HB 2005 followed by the passage of HB 2097 would provide an excellent opportunity to "test" a durable medical equipment mandate, including its costs, before requiring it of other insurers. Thus, if the cost proves too overwhelming, the mandate could be withdrawn.

The financial impact of having a disability or a family member with a disability can be staggering. Those individuals and families who attempt to keep abreast of the costs find that funding DME is a major financial hardship. In addition to paying for health insurance premiums, they must also pay for DME costs beyond the policy limit as well as for uncovered items. People often call the *Assistive Technology for Kansans* project seeking funding for DME. One of the few options available is to ask for assistance from civic organizations that sometimes provide such financial assistance. Few of us here today would want to be asking for this kind of assistance for ourselves or a family member on a regular basis. Yet this might be the only recourse for an individual needing the equipment, or whose child needs the equipment.

Insurance companies who provide adequate DME for their consumers have nothing to fear from this bill. For those who do not provide adequate coverage, we ask that you place the responsibility of payment for DME where it belongs, on health insurers who collect premium payments to cover such services.

Thank you for the opportunity to bring this issue before you today.

Assistive
Technology
For
Kansans

A Project
Coordinated by the
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At Parsons

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Information and
Referral Phone
800-526-3648
(Voice)
800-500-1034
(TTY)

Assistive Technology for Kansans
Durable Medical Equipment Bill
Report Required By Kansas Statutes 40-2248 and 40-2249

(a) The social impact, including:

1. The extent to which the treatment or service is generally utilized by a significant portion of the population;

Children and adults with disabilities, people who are elderly, and people who have experienced a serious illness or injury are the primary users of Durable Medical Equipment (DME). Although the majority of people with health insurance do not require DME on a regular basis, anyone can experience an serious illness or traumatic injury, and require DME at some point in their lives. According to figures contained in the Kansas Annual Summary of Vital Statistics, 1995 Kansas Kids Count Data Book, Digest of Data On Persons With Disabilities, there are approximately 464,889 individuals with disabilities residing in Kansas. Not all people with disabilities require DME.

2. The extent to which such insurance is generally available;

While DME is covered by some insurance companies, insurance providers typically place a policy limit on how much they will pay annually per individual. Such policy limits are typically in the range of $1,000 annually. This limit is often inadequate for children and adults with severe disabilities. Children with severe disabilities may require a change in equipment to allow for growth and/or several different types of DME each year, easily exceeding such policy limits. Adults with severe disabilities also experience problems with these policy limitations. For example, wheelchairs for adults do not need to be replaced as frequently as those of children. When one is needed, however, the cost well exceeds $1,000. Adults who sit in wheelchairs for long periods of time must have customized seating and positioning at an additional cost. If any other DME is needed in the particular year a wheelchair is purchased, the individual will have to seek supplementary funding.

Power equipment such as wheelchairs or scooters, even when prescribed by physicians as medically appropriate, are frequently not covered by health insurance companies. Power wheelchairs are expensive, costing as much as $10,000, or sometimes higher. Some health insurance companies will provide coverage for the cost of a manual wheelchair, leaving the individual to seek the remaining funding for the power wheelchair. Funding is frequently sought from federal, state, and private programs which are funded by taxpayer dollars or public funds. The cost of DME needs to be shifted from taxpayers to health insurance programs designed to meet the medical needs of people who pay insurance premiums.

3. If coverage is not generally available, the extent to which the lack of coverage result in persons being unable to obtain necessary health care treatment;

Inadequate coverage of DME can leave the individual without the necessary equipment, resulting in further deterioration and in some cases institutionalization. The cost of institutionalization is much higher than DME and places a higher burden on taxpayer dollars.

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;

The cost of having a disability or having a family member with a disability can be extremely high. In addition to the cost of DME, individuals with disabilities may also have to deal with the costs of medical care, medication, medical supplies, therapy, etc. This can prove to be a significant financial hardship. In some cases individuals have to rely on government funded programs to supplement their medical care, placing the financial burden on federal/state programs funded by taxpayers rather than on insurance companies.

5. The level of public demand for the treatment or service;

DME is only used by some elderly people and children and adults with serious health problems or disabilities. The majority of the insured population does not require DME on a regular basis, nor would many people opt to use DME in the absence of a serious illness or disability.

6. The level of public demand for individual or group insurance coverage of the treatment or service;

Most of the insured population does not require DME on a regular basis. In the event of a serious illness or temporary or permanent disability DME may be needed. It can be assumed that everyone who pays for health insurance coverage would want to have adequate DME coverage, if needed.

7. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts, and;

Unable to assess this level of interest.

8. The impact of indirect costs which are costs other than premiums and administrative costs, on the question of costs and benefits of coverage.

None known

(b) The financial impact, including;

1. The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;

It is doubtful that this coverage would result in either the increase or decrease of the cost of DME.

2. The extent to which the proposed coverage might increase the use of the treatment or service;

This coverage would not result in increased usage of DME in the general insured population, as most able-bodied individuals would not choose to use DME in the absence of an illness or disability. DME is primarily used because of the presence of a medical condition, to prevent further debilitation, to increase independence, and/or to prevent higher cost care. Even with the passage of this bill, the medical need for DME must be established by a physician, and the appropriate equipment prescribed.

3. The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;

Professionals in the field of aging and disabilities report that inadequate DME coverage can result in persons being institutionalized, specifically nursing home placement. Institutionalization usually occurs because of physical deterioration, lack of independence, and/or physical hardship on care givers. Institutionalization is much more costly than providing DME within the individual's home. Funding for many who are institutionalized is usually provided by federal/state programs, and ultimately, taxpayers.

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; and

(See attached memo from the Office of the Insurance Commissioner).

5. The impact of this coverage on the total cost of health care.

While more DME might be purchased by private insurance for a limited segment of the insured population, the overall cost of health care coverage might be positively impacted by preventing further physical deterioration and the possibility of hospitalization and institutionalization.

Testimony in Support of House Bill No. 2097

I, Marcelle Shrake, support the passage of House Bill 2097 increasing the limit of durable medical equipment allowance to $10,000 per calendar year due to the following example.

A wheelchair necessary for my three-year-old son was purchased in May 1997 for $3,800 with a $500 write-off leaving a balance of $3,300. The primary insurance (Blue Cross & Blue Shield of Kansas) paid $2,500 which left a balance of $800. Our secondary insurance (United Healthcare) paid $680 or 85 percent which resulted in $120 of out-of-pocket expense. This used up the allowance for the 1997 calendar year and forced me to put off purchasing a walker and the therapeutic electrical stimulation program (an approximate total of $2,700) which were indicated as medically necessary by our primary care physician through the Spina Bifida Clinic at Children's Mercy Hospital in Kansas City, Missouri.

I do not feel that my ability to pay for equipment, that will enable my son to walk, should be held hostage by an outdated monetary limitation on durable medical equipment. The $10,000 durable medical equipment allowance being proposed is much more realistic considering the cost of even the simplest equipment available today. It is obvious that $2,500 will not even buy a wheelchair for a three-year-old child. My son's access to the necessary equipment that will enable him to overcome or even adapt to his disability is being arbitrarily denied due to this allowance. As his parent and advocate, I am being put in the awkward position of delaying my son's progress, because I cannot afford what he needs, when he needs it.

At issue is the access to the equipment, not whether the equipment is worth what it costs. I respectfully ask this body to grant my son access to the equipment he needs by recommending the passage of this bill.

Marcelle R. Shrake
1916 SW Wayne Ave.
Topeka, KS 66604-3139

ATTACHMENT # 4
HOUSE COMMITTEE ON INSURANCE
MARCH 4, 1999

March 4, 1999

To: The House Committee on Insurance
From: Connie Broadbent
3546 SW Auburn Rd
Topeka, Ks 66414
(785) 478-3275

Reg: Support for the Durable Medical Equipment Bill, House Bill No. 2097

My son, Andrew Sterling, was a healthy, strong athelete until April 18, 1997, when he broke his neck playing high school baseball. My son is paralyzed from the chest down and is now a quadriplegic. The injury itself was a nightmare beginning with six months of acute in-patient hospitalization. We soon found out, however, that the worst nightmare was yet to come in dealing with our primary health insurance company. The insurance company should have been our ally and best friend, but instead, became our worst enemy! We were made to feel like criminals just because we were asking for payment for out-patient durable medical equipment needed to care for our son.

Our primary insurance policy only had an allotment of $1,000 per fiscal year for durable medical equipment. That amount was used up the first week post discharge from the hospital. I was never successful in obtaining anymore than the $1,000 for durable medical equipment from our primary insurance company. We were denied in our requests for the durable medical equipment and attendant core needs.

My son was fortunate, in that he had a secondary insurance policy, that was provided for by the high school. It took nine months of appealing and reappealing to this secondary insurance company before we began to receive payment for the durable medical equipment purchased. This was accomplished with the assistance of the National Spinal Cord Injury Association, the family service guidance counselor at Craig Hospital, and the Kansas Insurance Commissioners office. We were fully reimbursed!

Below is a list of durable medical equipment purchased for Andrew over a one year period. The total cost of that equipment was $91,148.66. By finally receiving reimbursement from the secondary insurance company, it kept our family from filing bankruptcy!

Equipment	Cost	Equipment	Cost
Hospital Bed/Mattress	$2,545.00	Electric Wheelchair	$24,330.42
Manual Quickie GPV Wheelchair	$4,045.00	Hoyer Lift	$1,324.00
Shower/Commode Chair	$1,851.00	Digital Blood Pressure Cuff	$59.98
Arm Brace	$995.00	Foley Catheter Supplies	$800.52
Easy Stand-Up Machine	$1805.43	Wheelchair Repairs	$147.42
*RCIL (attendant care hours)	$47,320.00	Naturally Speaking Dragon Dictate Computer	$2,695.00
Speaker Phone	$399.99	I.M.S. Conversion Van (transportation)	$39,346.00
Intercom System	$95.79	American Accessibility Systems (stairglide lift)	$7,232.86
Accessible Roll-In Shower	$958.00	Handicap Grab Bars	$172.44
Shower Head Flex Hose	$52.80	Bathroom "Heat" Lamp	$65.00
Automatic Door Openers	$2,227.01		

With today's high technology, there is all kinds of durable medical equipment available to these clients, but they will never be able to use them because they are unaffordable without the assistance from the health insurance companies. With the use of proper durable medical equipment, clients stay healthier longer, and out of expensive health care institutions, costing insurance companies less.

I thank you in advance for considering passing this important bill. Please keep in mind that health care has been rapidly changing during the past five years---switching as much care from the in-patient setting to out-patient care. The health insurance companies however have not yet kept up with that trend and have failed to meet the needs of policy holders in this area of out-patient needs and durable medical equipment.

Thank You,

Connie L. Broadbent

Connie Broadbent

ATTACHMENT # 5
HOUSE COMMITTEE ON INSURANCE
MARCH 4, 1999

House Committee on Insurance
House Bill 2097 Testimony

Thank you for the opportunity to come before you today in support of House Bill 2097. Each of the three sections of the bill personally effects my daughter, Jessica, and me. I will address each in turn.

One, because there is not a unified definition of DME, insurance companies and consumers often disagree on the types of equipment to be covered. An expanded definition of DME would be helpful when trying to advocate for equipment to be covered by insurance policies.

Two, raising annual policy limits of DME would greatly impact our lives. Jessica, my daughter is a seven year old diagnosed with cerebral palsy. She requires a wheelchair or other ambulatory aides for mobility along with a wide array of different equipment. In 1998 alone, Jessica required a walker ($500.00), foot braces ($400.00), and a bath chair/support ($600.00). These three items exceeded our policy's DME limit of $1,000.00 per year, in less than six months. Since I am a single parent, our family has only one income. There is seldom extra money to purchase items that are essential in Jessica's life.

Only a few years ago Jessica's health status required equipment so that she could live at home instead of in the hospital. She used a feeding machine ($150.00 per month) and a heart monitor ($60.00 per month) this doesn't include the expense for feeding bags, gauze, etc. Such equipment exceeded our DME limit in much less than a year. A minimum $10,000 per individual is a more reasonable annual policy limit. There are companies in the state who provide policies with unlimited DME coverage if the equipment is medically necessary.

Insurance coverage for Kansans is dismal. The durable medical equipment ceiling within every insurance policy covering Jessica has fallen far short of meeting her needs. This limited coverage has forced me as the bread winner to abandon opportunities for career advancement so that my earnings would remain within the income guidelines set forth for Medicaid eligibility.

Lastly, Jessica's doctor wrote a prescription for a power chair stating that it (the power chair) is an essential step toward independence for her. If a device is prescribed by a physician, i.e. deemed medically necessary, coverage should be provided. Jessica has recently accomplished her goal of getting a power chair. With a power chair Jessica's need for attendant care services has decreased resulting in a significant savings to taxpayers. With a price tag in excess of $7,000.00, it was a challenge for us to find funding. Our insurance was unable to cover even a portion of the cost because it does not cover power equipment.

I hope this information proves helpful to you in understanding what effect this bill will have on my daughter's life. I ask for your support in passing this necessary bill. HB 2097 will make a significant difference in our life and the lives of many families and individuals with disabilities.

Thank you

Jennifer Schwartz

Jennifer Schwartz
3004 W 30th Court
Lawrence, KS 66047

ATTACHMENT #4
HOUSE COMMITTEE ON INSURANCE
MARCH 4, 1999
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I, Robert L. Shrake, wish to provide testimony in support of House Bill 2097, which would mandate an increase in the existing Durable Medical Equipment Allowance (currently $2500) to $10,000 per calender year.

In complete agreement with the testimony provided by my wife, Marcelle Shrake, and her account of the situation and circumstances surrounding the acquisition of a wheelchair for our son, Jasper, I wish to add my thoughts and describe some of my feelings about this subject.

When it became apparent that we were, in effect, being forced to postpone necessary therapy due to the out-of-pocket costs involved, I was very worried about the long-term effect that this decision would have on my son's ultimate ability to overcome, or even cope with his disabilities. Every resource we consulted detailed the need for early intervention and aggressive therapies. At the clinics, specialists in every field... from neurology, orthopedics, urology, nutrition, pediatrics, occupational and physical therapists... agreed that Jasper needed to begin NOW with his daunting programmes.

As overwhelming as all of this advice was, My wife and I took solace in the fact that the one thing we would not have to face, would be having to decide what Jasper's future would cost. After all, we were blessed not only with an otherwise healthy, bright, and loving child... but also with two excellent Health Insurance policies purchased through our respective employers: a rare and valuable circumstance in these times when so many families can afford no insurance at all. This knowledge was a genuine relief to us and both our families, allowing us to devote all our emotional resources to getting Jasper on track. Our financial resources were already taxed simply by having to buy a (used) van for the anticipated transport of his wheelchair, and the quarterly trips to Children's Memorial Hospital in Chicago for bladder stimulation therapy (to increase the size of his bladder without resorting to augmentation).

When we actually fitted Jasper for his chair, the sticker-shock took both of us for an emotional roller-coaster ride. We were actually put in the position of having to decide whether to effect his development with the mobility he needed to explore and learn about his surroundings, or to buy a walker so he could practice his balance and walking at home as well as at therapy...the real problem was that he needed to begin Therapeutic Electrical Stimulation for the upper-body strength needed for <u>both</u> activities. Tragically, this was going to have to wait until we could afford it.

If Jasper was to ever learn to walk, it was incumbent upon us, his parents, to timely facilitate all the resources necessary. Our frustrating inability to do just that at the time it was needed most would not have occurred but for the arcane and unrealistic limitations imposed by our insurances.

As for the cost of this bill, consider the cost to our communities when another child is delayed the tools they need to overcome their disability. It doesn't have to be reduced to the absurd to comprehend the chain of events. Feel free to contact us and allow us to express the consequences of this decision we made.

3/4/99 Testimony in Support of House Bill No. 2097
(Durable Medical Equipment)

My name is Dot Nary and I live at 1801 Maple Lane, Lawrence, KS. I am a graduate student and research assistant at the University of Kansas. I've been a wheelchair user for about ten years, and worked in the field of independent living for persons with disabilities before I returned to school.

One of the most persistent and serious problems faced by people with disabilities who work is the limitations in coverage imposed by private insurance companies, particularly in the area of durable medical equipment. While this equipment is no more expensive than many medical procedures, insurers have traditionally seen it as an area in which they could successfully restrict benefits.

From the perspective of persons with disabilities, several points are very clear:

1. The patient/health care provider team is best equipped to make decisions about whether and/or what type of durable medical equipment is needed. These decisions should not be arbitrarily made by an insurance administrator, or worse, an insurance clerk;

2. The definition of equipment must be broadly defined in terms of function, in order to address and support the wide range of disabilities and functional limitations;

3. Policy limits should not be set to save insurance company dollars, but must realistically reflect the actual costs of such equipment.

4. State level policy regarding DME is needed because employers may choose a plan with inadequate DME benefits which will not meet the needs of present and future employees, and their family members, with DME needs, or present employees who may sustain disabilities and require DME in the future.

My chairs cost about $2500 and last for about three years of intensive use. This lightweight chair gives me the ability to move about quickly and efficiently, with a minimum of maintenance and breakdowns, and with a minimum of wear and tear on my joints. My cushion costs about $400, lasts about the same length of time, and allows me to sit for an average of 18 per hours a day. It prevents me from getting pressure sores, one of which can cost up to $90,000 to heal. These durable medical goods allow me to work, attend classes, keep house, recreate, volunteer in the community, just as a non-disabled person does.

When I obtained this equipment, I was covered by an insurance plan with liberal durable medical equipment benefits that covered most, but not all, reasonable needs. I am now covered by an HMO that imposes a limit of $1000 dollars per year on equipment. The policy does not allow the amount to be carried into the next year if it is not used. Therefore, in any calendar year, I can get less than half the amount of a wheelchair paid for, even though I am paying the same insurance premiums as anyone else. To me, this is like saying, yes, we will cover your open heart surgery but only up to $1000.

(over)

ATTACHMENT # 7
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MARCH 4, 1999

When I first started to use a wheelchair, I worried about how I would continue all of my activities as a wheelchair user. Now, I know that I can do just about anything that I could do when I walked but I worry whether I'll be able to get the right kind of equipment that I need when I need it.

For my colleagues and friends with other more involved types and levels of disability, durable medical equipment may allow them to negotiate the community in a power chair, communicate with an assistive communication device, or access the benefits of cutting edge technology for a variety of other very functional and necessary purposes.

Of course, insurers will argue against amending the insurance laws on a piecemeal basis, and will threaten that premium increases will exclude more people from the system. I personally feel that the health care system needs more systemic change for a variety of reasons. However, until or unless occurs, people with disabilities need assurance that our very basic needs, including the those of mobility, communication, and other activities, will be met. Other groups have argued successfully for inclusion of other tests, services, and/or devices that will benefit a specific population. I believe that the issue of assistive technology is equally important.

In addressing this issue, we must also consider that the insurance industry is claiming hardship as an argument against increases in durable medical equipment coverage, at a time when executive compensation in the industry continues to climb. Families USA, a national consumer watchdog organization, reports that while the health maintenance organization industry as a whole posted losses for 1997, HMO top executives earned an average of $2 million each in 1997. The highest paid executive at Oxford Health Plans earned $30,735,093, exclusive of unexercised stock options. The HMO executive with the largest of these unexercised stock options was the CEO of United HealthCare, who was allowed $61,178,652 in stock options. (This Families USA report, which includes study methodology, can be obtained by calling the organization at 202/628-3030.)

To quote Ron Pollack of Families USA, "The hypocrisy of the industry on the issue of health care costs is startling. They lose money in 1997 but spend millions to compensate their top executives, spend millions on advertising and lobbying to kill patient protections, and then they go around scaring the American public saying they will need to raise premiums to cover the very minor costs of comprehensive patient protections." To quote disability rights activist and recent Presidential Medal of Honor awardee, Justin Dart, "I am willing to die for my country, but not for my insurance company." Insurance company profits should not be placed about the legitimate needs of people with disabilities. And that could include anyone in this room at any time, including insurance company lobbyists.

My generation is one of the first in which those born with spina bifida, my disability, have both survived and thrived. We are the first generation to benefit from civil rights legislation, including the Americans with Disabilities Act, that guarantees equal access to the workplace, public accommodations and transportation. And we must be the first generation able to work, achieve and contribute to society unhampered by artificial, capriciously imposed insurance limitations that prevent us from accessing technology that supports us, enhances our lives and abilities, and is vital to our continued functioning and health.

March 2, 1999
By Nora Manier

My name is Nora Manier. I have worked for the state of Kansas for 24 years. I'm here today to testify for the Durable Medical Equipment Bill issue.

My daughter, Jessica Moss, was born with Brittle Bones and she has never walked. Jessica has used a power wheelchair for 10 years. The money for her first chair was raised through bake sales, dances, raffle ticket sales on donated items and other very generous donations. Jessica's first power chair cost $6,500.

In February of 1997, her first power chair fell apart and died. The technology had changed so much that parts were no longer available for it. Power chairs usually last 5 to 6 years. Jessica's chair was 9 years old. Thus, the search for another power chair and funding for it began.

My first call was to my insurance company based here in Topeka. I was told that I could receive up to $2,500 to $3,000 toward a power chair. Apparently, the company only assisted with power chairs, but they would purchase a manual chair and the $2,500 and $3,000 figures were what a manual chair would cost.

The Assistive Technology for Kansans project and the Southeast Kansas Independent Living Center assisted with the funding of my daughters new chair which cost $16,000. The last $2,000 needed was raised by Jessica's classmates. My insurance company did not provide any of the money for this chair.

As of today, my insurance company has not told me why Jessica was denied funding. Letters were sent to the insurance company telling them of the need.

Jessica attends Parsons High School and is on the Honor Roll. She's a girl scout, participates in plays, keeps score at volleyball games, and she would like to be a pediatrician someday. We're here today to urge you to consider helping us and others in need of necessary Durable Medical Equipment to increase the amount that insurance companies will pay.

Thank you for your time.

ATTACHMENT # 8
HOUSE COMMITTEE ON INSURANCE
MARCH 4, 1999

Testify in Favor of Senate Bill No. ~~509~~ 2097

I have been a quadriplegic for the last eleven years. In order to perform essential daily living tasks, I rely on two wheelchairs–a shower-commode wheelchair and a manual wheelchair.

My wife and I both work full-time, and are fortunate enough to have health insurance; some families are not. However, even the insurance we have falls short in the area of Durable Medical Equipment due to exclusions and coverage limitations.

I would like to relate my personal experience regarding these limitations. Even though I am able to maneuver a manual wheelchair, I'm only able to do so in very flat and smooth areas. A standard electric wheelchair starts at about $9,000. The durable medical allowance, with my insurance, is $2,000.

Not having an electric wheelchair makes me less independent. I have to depend on people to push me if there is a great distance between the places, an also up small an large inclines.

Even though my wife and I both have good, full-time jobs, it still does not afford us the luxury of having six thousand extra dollars for an item such as this.

Another example of limitations that the insurance industry puts on DME, the inconsistent interpretation of coverage.
For example, I was in need of a new shower-commode wheelchair, because the one I had used for the previous 10 years was beyond repair. I contacted the insurance company to ask them if they covered this item, and they stated they did. So, I went to the medical supply store and ordered one. The salesman submitted the purchase to the insurance company, and it was denied–because the insurance company felt that it was a "luxury item."

After receiving a letter of denial, I contacted an insurance company representative, and asked him if <u>his</u> being able to take a shower and use the restroom was merely a luxury or if it was a necessity. The gentleman thought about it, and said he would take it to the board for another review. A couple of weeks later, I got a letter in the mail stating that the insurance company had approved the purchase, and that they would be paying 80% of the cost. This piece of equipment is not cheap either–it costs $1800.

In closing, I would challenge each of you, today, just to stop and think, "What if that was me? What if I had to rely on the Durable Medical Equipment policy as it is today? Would I be able to get the equipment that I need? This could be answered in the affirmative, through the passing of Senate Bill No. 509.

Respectfully submitted,

Shaun C. Spotted Horse
1922 Regency Parkway, Apt. A
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ATTACHMENT # 9
HOUSE COMMITTEE ON INSURANCE
MARCH 4, 1999

Testimony in favor of passage of House Bill No. 2097

I wish to testify in favor of House Bill No. 2097. This bill is necessary for the following reasons:

1. To provide the opportunity for individuals with disabilities to reach their full potential
2. To bring insurance coverage for DME up-to-date with inflation, technology, and price increases
3. To require the insurance industry to accept and cover physician-prescribed DME (including power wheelchairs and scooters) when necessary

My son Joshua was born with spina bifida, a birth defect in which the spinal column has not closed properly during formation. In Joshua's case, this resulted in limited sensation and muscle control in his upper legs and no sensation or muscle development in his lower legs. Joshua has a shunt to control excess fluid in his brain, and is also on a regular catheterization schedule to maintain the health of his bladder and kidneys. In addition to being the mother of a child with a disability, I am also a founding member of the Spina Bifida Group of Topeka and serve on the Assistive Technology for Kansans Task Force. I wish to share some experiences and stories with you today to help you understand the importance of the passage of House Bill No. 2097.

Joshua is currently three years old and is enrolled in the early childhood development program in our school district. His primary means of mobility include crawling, using a manual wheelchair, and walking with a walker and the aid of full-leg braces. My husband and I are committed to helping Joshua achieve his full potential. We are fortunate enough to have health insurance, some families are not. Even with insurance, however, there are often times the coverage falls far short of the need, especially in the area of durable medical equipment exclusions and coverage limits.

Joshua received his first wheelchair and walker in December, 1996. The walker was received on time, but due to delays at the manufacturer, the wheelchair was not received until the first day of our 1997 insurance plan coverage year. His first wheelchair, received when he was just over two years old, cost approximately $2,000, just under our insurance plan's annual DME limit. It is not uncommon for a child's first wheelchair to cost anywhere from $2,000 - $3,500 for a manual chair.

At that same time, we chose to pursue an additional form of treatment for Joshua known as Therapeutic Electrical Stimulation (TES) which is used to stimulate and develop muscle strength and growth. A battle ensued with our insurance company who refused to accept our specialist's recommendation that our son pursue this therapy. Eventually, our insurance company agreed to coverage for our son (the same week they refused coverage for this treatment for another family with a child who has the same diagnosis and insurance plan as we do). However, the equipment needed to pursue this therapy was considered DME. Now we had a choice to pursue the therapy and absorb most of the $1,500 cost ourselves, or to wait an entire year and hope we would not have additional DME expenses in the following coverage year. In order to give Joshua the most benefit, we had no choice but to pursue the therapy at our own cost.

This is just one example of the choices that families face in trying to maximize the abilities of their disabled children without sacrificing their family's ability to live. I have personally battled on multiple occasions with our insurance company to receive coverage for treatment that was approved and recommended by the specialists who know and work with our son, but was determined to be "not necessary" by our insurance company.

Another factor addressed in this bill is the rising cost of DME, with no corresponding rise in the DME limits. One of our durable medical equipment vendors that I spoke with stated that the price increases that the industry has seen in the past 10-20 years have resulted not only from inflation but from the technology that has been developed and is

HOUSE COMMITTEE ON INSURANCE
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MARCH 4, 1999

allowing people with disabilities to be more active and productive citizens than ever before. This is a benefit to all of society.

In defending their position, the insurance industry will tell you that this bill will cause some Kansans to lose medical insurance, that it will only cover approximately 30% of those who are insured in the State of Kansas, and that they should not be mandated to cover extravagant DME. I understand that this bill is not without controversy. The passage of this bill may cause some Kansans to lose their health insurance but I am here to tell you that by not passing this bill, you cause many families to do the same. I personally know families who, in an effort to obtain what they feel is the best opportunity for health care for their disabled child, have left employment and purposely keep their family's income at or below a level that will qualify them for a medical card for their child. This is the only way they feel they will be able to meet their child's needs for those items that would not have been covered by their private insurance. Some of the families call it "playing the system". I call it an injustice that families who have paid medical premiums for years find that when they truly need the coverage, it is not there to the extent they need it and they are forced to look elsewhere, and the burden is shifted from the insurance industry to the taxpayer.

In response to the fact that this bill will only cover approximately 30% of Kansans, I say great! It is a start, it sets a precedent. No one ever imagines they will need this coverage. I never dreamed my life would lead me to this moment, but here I stand. As a State employee, I will not benefit directly from the passage of this bill, but I am here today because I know others will. It will have a dramatic effect on the lives of many Kansans.

I know the insurance industry will make it seem as if we are asking for the moon. We are not asking for bells and whistles here, we are asking for equipment that is prescribed to meet the needs of the disabled individual. It angers me to see individuals whose only opportunity for mobility is through the use of a prescribed electric wheelchair be told they are only worth the cost of a manual wheelchair. I have also met those who need hearing aides, or augmentative communication devices and are told these are not covered services. Their families are forced to do without, or raise the money elsewhere. These individuals face the challenge of overcoming a disability every day of their lives. You and I have no idea what that is like. Once-in-a-while we are inconvenienced with a twisted ankle or bad back which does not allow us to move as quickly as we would like. Or we experience a bad cold which clogs our ears making it difficult to hear, or laryngitis for a day or two which keeps us from being able to talk and communicate with others. These individuals face these challenges every day of their lives. Imagine being told that the technology is available to help ease this challenge and to create new opportunities, only to be told it is only partially covered, or is not covered at all. Imagine being told that it is not considered "medically necessary" for you to be able to walk, move, hear, or communicate.

In closing, I would challenge each of you as you leave today to stop and think as you stand up from your chair, and walk into the rest of your life. Think of those in this room who will never experience that feeling, those whose life is dependent upon DME simply to be able to get from here to there. Stop and thank your Creator that you have been blest with the ability to walk, to hear a small child whisper a secret in your ear, and to be able to say, "I love you" to the people that matter the most to you.

Individuals with disabilities are priceless. They have the ability to change the world if the world will give them a chance. You have the ability to change their world. You have the opportunity through the approval of House Bill No. 2097, to give them that chance.

Respectfully submitted,

Nancy T. Ruoff

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Memo To: Chairman Tomlinson and Members of the House Insurance Committee
From: Sherry C. Diel, Deputy Director
RE: HB-2097--Mandated Coverage For Assistive Technology Devices
Date: March 4, 1999

What is Kansas Advocacy and Protective Services, Inc.?

Kansas Advocacy and Protective Services, Inc. ("KAPS") is a federally funded non-profit corporation. Our agency serves as the designated Protection and Agency for persons with disabilities in the state of Kansas. Each state and territory in the United States has a similar type of organization. Our role is to advocate for legal rights and services for persons with disabilities. Pursuant to federal law, KAPS has authority to pursue resolution of disputes through use of legal, administrative and other appropriate remedies. Because our funding is limited, KAPS utilizes priorities, developed as a result of public input, to advocate for systemic changes in the public and private sector to benefit Kansans with disabilities.

KAPS Position On HB-2097.

KAPS generally supports HB-2097 with the possibility of amendments to limit the definition of Durable Medical Equipment (DME) and to the yearly cap on DME coverage.

Although insurance mandate is not a phrase that all persons support, mandated coverage for DME is important to persons with disabilities and our elder population. Too many times, persons with disabilities and our elder population are prevented from enjoying independence and dignity because they are unable to access DME from public or private sources. Without access to DME many persons with disabilities are prevented from joining the workforce. Persons with disabilities and our elder population are isolated in their homes because of lack of mobility or communication devices. Public funding sources often are limited, leaving the person unable to purchase high-end items such as a motorized wheelchair, a scooter, a CCTV, or an augmentative communication device. KAPS believes that a partnership between the private and public sectors in the purchase of DME will greatly improve the lives of persons with disabilities and our elder population.

KAPS is aware that the insurance industry will likely lobby hard against any further insurance mandates. KAPS believes there is room for negotiation, however.

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1. KAPS is not opposed to limiting the definition of DME somewhat to cover a more narrow range of communication devices, low vision devices and mobility devices. KAPS is hopeful that consumers, advocates and the insurance industry can negotiate a definition that is not all-encompassing, but meets the needs of persons with disabilities and our elder population.

2. The yearly cap of $10,000 is probably more than is necessary for the purchase of most DME, because DME is durable and expected to last for a period of approximately 3-5 years. For instance, a child who requires a manual or motorized wheelchair may need to replace the wheelchair quite frequently as the child grows. However, an adult can use a wheelchair until it simply wears out and needs replaced. KAPS would support an amendment that places the $10,000 limitation over a period of 2-3 years. KAPS believes that simply reducing the yearly cap will still keep the high-end items out of reach of most of our consumers and elder population who, oftentimes, live on fixed incomes.

3. If this DME coverage is mandated, and the Senate passes HB-2005, DME would be tried out on the State Health Insurance Plan for a period of 18 months. Both the consumers, advocates and insurance industry will have the data available to evaluate the true cost and benefit of DME coverage on the insurance industry and the lives of Kansans.

Thank you for the opportunity to address your Committee. I will be happy to address your questions, or you may reach me at (785) 273-9661.

InterHab
The Resource Network
for Kansans with Disabilities

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March 4, 1998

TO: **The House Committee on Insurance**
FR: **In support of House Bill 2097:**
A bill to require insurance coverage for durable medical equipment.

Thank you Rep. Tomlinson and members of the committee for the time you will spend in today's meeting to hear testimony regarding House Bill 2097.

I am Tom Laing, Executive Director of InterHab, a statewide group of organizations that provide supports and services to Kansans with disabilities. Our 48 organizational members include 46 Community Service Providers, and all 28 of the state's community developmental disability organizations, gatekeepers of the state developmental disability service network. Our members provide services in every Kansas county, and every one of our members serves persons whose lives would be improved by the policies proposed in HB 2097.

I am not here today to address the technical aspect of the insurance policies embodied in this bill, but to address first the process by which such policies are considered and secondly, to respond to some dialog that has arisen over this bill.

1. First, let me offer our position on the process.

Kansans who would benefit from this bill saw the concept die in the Senate last year without a vote on the floor, and should not experience a similar frustration this year, especially not from a Legislature which prides itself on its reputation of being open and responsive to citizens' concerns.

Our organization supports House Bill 2097, and recognizes that under the current scenario, under the legislative rules, unless something changes, this bill cannot pass this year. However, we also understand that the House can take any number of routine parliamentary actions to provide the exempt status that would enable this bill to be considered.

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Therefore, we urge this committee to work the bill, act favorably on it, and take the steps needed to give this bill a chance on the House floor.

2. Additionally, we have comments on a number of the issues that have arisen in the months of discussion on this bill:

As regards concerns voiced last year by the health insurance industry regarding cost, we recognize you have a duty to hear and address the concerns of the industry.

There is no question that a DME coverage requirement will have a cost impact on insurance policies. However, it is worth noting that the estimates from the industry made prior to the introduction of last year's bill suggested that the impact would be modest, and that the later estimates, offered in response to SB 509 in the 1998 session, were far higher, and did not bear up well under the scrutiny of public testimony.

As regards the general political sentiment against mandates … This so-called mandate is really a law to end *de facto* discrimination against persons whose health circumstances do not fall into the laws of averages that govern actuarially-based insurance policies.

Under current law, which allows DME to be non-covered, any company that provides such coverage is at a competitive disadvantage in the marketplace, and thus available coverage is sparse.

The effect is a smaller health insurance marketplace for Kansans with disabilities, and higher policy costs resulting solely from the circumstances of their disability.

Are there alternatives? Yes. All Kansans who need durable medical equipment could become Medicaid-eligible in order to utilize the public assistance which may be available for Durable Medical Equipment, and to become eligible, they could abandon any meaningful employment, and thereby remain below the income threshold in order to protect their income-eligibility for Medicaid.

Or, all Kansans in need of durable medical equipment should rely on charity to meet their essential living needs.

The alternatives, i.e. the *status quo*, are unacceptable.

Summary:

We believe this issue must be addressed.

It is a quiet crisis that deepens the sense of isolation and frustration that is common among these our neighbors for whom chronic unemployment and impoverishment is still the principle issue to be resolved.

For those who have created a viable economic niche, the DME issue is an unfair that holds them back.

Please remember, everyone in this room, and each of your family members, would potentially (if not immediately) be a beneficiary of this proposal.

Without such solutions, consider how you might deal with the issues we are discussing today.

We urge your action.

THE CEREBRAL PALSY RESEARCH FOUNDATION OF KANSAS, INC.

Testimony before the House Committee on Insurance
Regarding House Bill 2097
Patrick A. Terick
Cerebral Palsy Research Foundation of Kansas / United Cerebral Palsy of Kansas
March 4, 1999

Thank you Mr. Chairman, my name is Pat Terick, I am the Director of Governmental Activities for the Cerebral Palsy Research Foundation of Kansas (CPRFK) and Public Education Specialist for United Cerebral Palsy of Kansas (UCPK).

The Cerebral Palsy Research Foundation of Kansas and United Cerebral Palsy of Kansas are in support of House Bill 2097 which shall provide coverage for durable medical equipment in the amount of at least $10,000 per individual per year.

We also see that durable medical equipment is very expensive, items can cost anywhere from $700.00 to $20,000.00, many families and persons with disabilities have low incomes and need for durable medical equipment. Over the last decade we have seen how durable medical equipment has provided for greater independence to persons with disabilities.

Our organizations have assisted families and persons with disabilities in obtaining durable medical equipment. We try to be creative in assisting them with their purchase of durable medical equipment. This bill will give families and consumers greater assistance by providing coverage for durable medical equipment in the amount of at least $10,000 per individual per year.

The Cerebral Palsy Research Foundation of Kansas and United Cerebral Palsy of Kansas supports the passage of HB 2097.

Thank you Mr. Chairman and members of the insurance committee for supporting persons with disabilities.

Respectively submitted,

Patrick A. Terick
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MARCH 4, 1999

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ORAL TESTIMONY PRESENTED TO THE HOUSE COMMITTEE ON INSURANCE
March 4, 1999

RE: HOUSE BILL No. 2097

Good afternoon. I am Joyce Byrd, the Chairman of Shawnee County Advocacy Council on Aging. The 20 (volunteer) member Council's responsibility is to be advocates of issues and needs for all elderly persons residing in Shawnee County and make the Shawnee County Commissioners aware when such issues or needs are not being met. The Council is also responsible for advising the Commissioners on an equitable distribution of the county Aging Mill Levy so that funded agencies supplying needed services to the elderly are held accountable. I serve as a liaison to the Elderly Services Coordinator, Ms. Shimmel of Community Action and to Ms. Harris, Coordinator of Older Citizens Information of Community Resources Council.

I am personally supportive of this bill, HB #2097, because it addresses the issue of maintaining personal independence which can assist in lowering health care cost by reducing unnecessary hospital and/or nursing home stays. At the Council meeting on March 3, 1999, this bill was discussed and members present agreed that I relay their support of said bill.

We have been aware of the growing demand for but lack of adequate coverage or availability of prescribed Durable Medical Equipment and have sought ways for the Council to advocate for such needed equipment. Ms. Shimmel coordinates the only Durable Medical Equipment Lending program in Shawnee County, and she informs me that she receives a minimum of 5 referred calls per day (150 per month) and has a waiting list of at least 50 persons per month. Most of the referrals are from Jayhawk Area Agency on Aging or Project Access (Shawnee County Health Dept.), and doctors. The calls are requesting assistance in providing durable medical equipment since doctors will not release an elderly patient from the hospital to home until such medical equipment is in place. If the equipment is not available from the Lending Program, or private insurance won't provide or patient can not absorb the equipments' cost, the state has no choice but to place the patient in a long term care facility at Medicaid expense. Ms. Harris also receives 5 plus calls per day requesting assistance/referrals in locating or funding durable medical equipment. Ms. Shimmel states that the sad statistic is that many elderly patients will die before medical equipment becomes available simply because they can't afford the equipment that allows them to go home.

Durable medical equipment limits do not consider age, race, physical changes or progressive diseases. Today a quad-cane may be needed, but within six months a walker is required; however, since one walking device has been funded, the walker is not covered by Medicaid and is the sole responsibility of the elderly. Wheelchairs are covered but <u>one</u> time only so if a wheelchair wears out or breaks after a number of years use, and if the elderly person can't replace/repair at own expense; it's just to BAD. Most

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of the needed bath accessories (shower chairs, bath benches, stool risers, toilet sidebars, urinals portable commodes, etc.), anything that touches the naked skin , isn't covered by Medicaid or many insurance companies. However, these items are standard items for maintaining independence!

The demand is so great, that in January 1999 Ms. Shimmel raised the funds to purchase 20 new bath benches, but within three (3) days she had loaned them all out to referrals from Jayhawk Area Agency on Aging ; the receiving agency of the SRS Elderly Services Program!

The government continues to stress independent living in their own homes thus avoiding costly hospital and nursing home stays, so it appears that the State of Kansas, and the taxpayers will benefit economically with the passage of House Bill No. 2097.

Thank you for the opportunity to address you on this important matter.

Kansas Association
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Testimony before the
House Insurance Committee
The Honorable Robert Tomlinson, Chairman
Hearings on HB 2097
March 4, 1999

Chairman Tomlinson and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Brown Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and others who support managed care. KAHP members serve many of the Kansans insured by an HMO.

I'd like to thank committee members for tackling what are extremely difficult and emotional policy choices. At no time has KAHP opposed the content of any mandate bill or the ends they are attempting to achieve. KAHP's opposition has stemmed from the concern about the policy of regulation by mandate and the larger implications of mandates in that they will lead to a growth in the uninsured population in Kansas.

Currently, most health plans provide coverage for up to $1,000 annually per individual for durable medical equipment. Covered equipment includes: hemodialysis equipment, iron lungs, wheelchairs operated by hand, and hospital beds that are hand operated. When medically needed, plans generally cover electric wheelchairs or beds, but in such cases limit payment to the amount normally available for non-electric equipment. The current benefit structure is designed to balance the ordinary health care needs of most people who utilize durable medical equipment with the very important need to keep private insurance premiums affordable.

HB 2097 goes beyond the traditional understanding of what should be covered by health insurance, i.e. that which is primarily and customarily used to serve a medical purpose, can withstand repeated use, and could normally be rented and used by successive patients (HCFA's definition of durable medical equipment.) As described in HB 2097, covered durable medical equipment would include "equipment" not currently contemplated by existing health insurance programs, such as personal computers for those with learning disabilities and speech impairments, motorized scooters, and any number of similar examples which go beyond the bounds of current insurance benefits. Most people do not have health needs that require such equipment nor would they be willing to purchase health insurance that covers such equipment when they understand the increased premium cost associated with such coverage.

During the interim The Kansas Department of Health and Environment formulated a report estimating the cost impact of various proposed health insurance mandates. Included in the report is the estimated cost impact of the durable medical equipment mandate proposed last

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year which is exactly the same as the one before you. The estimated increased costs of health insurance to cover the additional equipment could reach 12%. According to a Congressional Budget Office report, the CBO estimated that nationwide, for every 1% increase in health insurance costs, 200,000 more individuals are added to the uninsured population. The State of Kansas is generally estimated to be 1% of the population of the United States. This means that for every 1% increase in health insurance costs in Kansas, an estimated 2,000 Kansans become uninsured. An increase of 12% becomes an additional 12,000 people uninsured in Kansas.

We know that self insured plans are exempt from state laws because they are governed by the Federal ERISA law. We also know that a state imposed health insurance mandate affects only a limited amount of Kansans who have health insurance. As Insurance Commissioner, Kathleen Sebelius stated in her testimony on health insurance mandates presented to the interim committee this past summer "only approximately 25% of Kansans with health insurance would be affected."

It is not the position of KAHP that persons in need of assistive technology be forced to do without or to live at less than their fullest potential. However, there are community, state and federal resources that provide many types of devices on a six month loan, such as Easter Seals. In addition, there is federal law that requires that each state have programs for children with special health care needs. Helping Kansans with physical challenges is a community concern, the cost of which should not be imposed solely on the limited amount of Kansans that are enrolled in fully insured private health plans.

The KAHP respectfully requests that HB 2097 not be passed.

Proposed Health Insurance Mandates
Analysis of Cost Impact

Special Committee on Financial Institutions and Insurance

Presented by:

Kansas Dept of Health and Environment, Statistical Agent for the Kansas Insurance Dept
Miller and Newberg, Inc., Consulting Actuaries
August 1998

Durable Medical Equipment - (DME)

SB 509(1998 Session)

This bill increases the annual coverage limit on DME from $1,000 to $10,000 and adds new types of equipment not previously covered by most insurers. Our estimate of the increase in coverage (current definition) amounts from $1,000 to $10,000 is 0.85% per year. The costs of additional types of equipment is harder to judge because the populations they would apply to are not known. The equipment would generally be for people with long-term disabilities, often people not insured under traditional individual and group insurance.

Examples of additional equipment covered are personal computers for learning and physically disabled, scooters, whirlpool, adjustable beds, etc. Given a reasonable estimate for the insured population with or contracting covered disabilities, we estimate increased costs up to an upper bound of about 12% per year.

Kansas Department of Health and Environment
Miller and Newberg, Inc.
August 1998

LEGISLATIVE TESTIMONY

the Kansas Chamber of Commerce and Industry
The Unified Voice of Business

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HB 2097

March 4, 1999

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Insurance

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

I am Terry Leatherman, with the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to express KCCI's opposition to passage of HB 2097.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 47% of KCCI's members having less than 25 employees, and 77% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

It is hard to find an insurance mandate initiative that lacks merit or emotional appeal. That is certainly the case with HB 2097. Durable medical equipment is needed and expensive. However, as this Committee certainly understands, passing HB 2097 will not prompt insurance companies to pay

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the ls. Instead, the cost will be passed along to all Kansans who receive their insurance throu policies governed by state law.

Those affected by insurance mandates are people insured in small groups and individual policies. These are also the people who have the hardest time finding affordable insurance. The net result of passing HB 2097 will be to make insurance more expensive, which drives more Kansans to choose not to purchase health insurance.

KCCI would also question the additional intrusion of government into the private insurance market, which would happen if HB 2097 becomes law. Insurance is a private sector contractual arrangement. The elements that make up an insurance product should be developed to meet the needs of consumers by insurance companies, not lawmakers.

Thank you for the opportunity to explain why the Kansas Chamber opposes HB 2097. I would be happy to answer any questions.

BRAD SMOOT

ATTORNEY AT LAW

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
Blue Cross Blue Shield of Kansas City
To
House Insurance Committee
Regarding 1999 House Bill 2097
March 4, 1999

Blue Cross Blue Shield of Kansas is a not-for-profit mutual insurance company providing health insurance to more than 700,000 Kansans in 103 counties. Blue Cross Blue Shield of Kansas City is a non-profit hospital and medical service corporation serving more than 200,000 Kansans in Johnson and Wyandotte Counties. Both Blue Cross and Blue Shield plans generally oppose mandated benefits because they tend to increase the costs of health insurance and thereby decrease the number of Kansas businesses and individuals who can afford coverage. On behalf of these Kansans, we must oppose House Bill 2097.

In 1997, Senate Bill 509 proposed a coverage mandate for durable medical equipment (DME) identical to HB 2097. The Senate did not act on SB 509 and instead, sent the bill to last summer's special interim committee on insurance mandates for further consideration. After extensive hearings, the interim committee chose not to recommend a DME mandate. The Department of Health & Environment, using an actuarial expert, estimated a .85% increase for the $10,000 minimum coverage and a 12% increase for the definitional change. As you know, a 1% premium increase equals $11.2 million. Thus, the $10,000 DME minimum coverage would equal $9.5 million and the definitional change could increase premiums for affected individuals and businesses by an additional $134.4 million.

As you can see, the real cost driver of HB 2097 is the expanded definition which increases the types of products which must be covered to include home modifications, computer equipment and software, lift devices, seating systems, etc. If you have doubts that the proponents of the DME mandate intend to expand the scope of coverage, just review their testimony from the interim committee and here. Attached to my statement is a list of DME products specifically requested for coverage under the mandate.

For the last several years, provider groups and advocacy groups have asked the legislature to intervene to force changes in health insurance coverage. These proposals have a common purpose, namely, to expand the scope of products or services covered by insurance and increase insurance payments to service and product providers. You are being asked to dictate to consumers the terms of the health insurance contracts they can buy. No where is this more clear than in HB 2097, where you are urged to redefine what is *health* insurance.

Attached is a chart entitled "What is *Health* Insurance." In regular bold type are those medical services that one would normally think of as health care services covered by insurance. In italics are the "life enhancing" coverages which mandate advocates requested during the summer interim. As you can see, many of these enhancements are ones advocated by the proponents of HB 2097. While all may be important to individuals or society, the question you must decide is whether such coverages must be included in health insurance policies for 37% of Kansans. We urge you to conclude, as the interim committee did, that the products or services proposed for mandated coverage under HB 2097 are neither affordable nor a fundamental part of basic health insurance coverage. Thank you for consideration of our views.

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DURABLE MEDICAL EQUIPMENT

Equipment Specifically Requested by Interim Conferees

- Electric wheelchair repairs and maintenance
- Pogan stroller
- Prosthesis (several over lifetime)
- Eye gaze computers
- Communication devices
- Seating systems
- Ramps
- Lift devices for vehicles
- Accessible showers
- Computer software
- Home modifications
- Scooters
- Programmable hearing aids
- Print to speech or Braille converters
- "Cutting-edge technology"
- Safety devices (bathroom handrails)
- Feeding machines
- Heart monitors

Legislative
Mandates

What Is *Health* Insurance?

BIRTH — DEATH

Prenatal & Birth

Emergency

Life Extension

Life Support

Health Education

**Pain Relief
& Management**

Infertility

Safety

Quality of Life

Life Activities

Life Enhancement

*Self-Esteem
(appearance)*

Productivity

Communication

Independent Living

Full Potential

Mobility

HOUSE INSURANCE COMMITTEE
Testimony on HB 2097
Presented by David A. Hanson
on behalf of
American Family Life Assurance Company of Columbus (AFLAC)
March 4, 1999

Thank you for this opportunity to present information on behalf of AFLAC on the proposed health insurance mandate in House Bill 2907 for durable medical equipment.

AFLAC has been active for many years in the sale of supplemental insurance policies in the state of Kansas. Presently, there are 45,405 active AFLAC policies in Kansas. AFLAC is the number one provider of guaranteed-renewable supplemental insurance policies in the United States (*National Underwriter,* July 1998), including specified disease, accident, hospital indemnity, Medicare supplement, disability and long-term care policies.

One of the primary roles of supplemental insurance products is to pay direct cash benefits to insureds to fill the gaps between comprehensive/major medical insurance coverage and the <u>total financial impact</u> of an illness or injury. These policies are designed and sold to provide <u>supplemental</u> benefits in the event of serious illness or hospitalization. Unlike comprehensive, major medical or basic health insurance coverage, supplemental insurance policies provide limited benefits at commensurably lower premiums. Benefits assist insureds with the "indirect costs" of an illness or accident, such as loss of earning power, child-care expenses, travel, lodging, food and more. Benefits are usually payable in addition to and regardless of other coverage.

Supplemental insurance products are not intended to be, nor are they marketed to be, substitutes for comprehensive/major medical health insurance. Because of the limited nature of supplemental insurance, there is no need to include supplemental insurance in the types of policies to which the proposed mandate would apply.

Because these policies provide limited supplemental benefits at proportionally lower premiums, attaching the proposed mandated benefits would fundamentally change the nature, as well as the costs, of these policies. Under a supplemental, limited-benefit policy, the cost for providing the additional mandated benefit would disproportionately increase the cost of the policy in relation to the other supplemental benefits it provides. Additionally, because the policies are intended to be <u>supplemental</u> to, rather than <u>substitutes</u> for, comprehensive/major medical health insurance, if benefits were mandated for all types of insurance policies, insureds would have a duplication of benefits, as well as duplication of premiums, without corresponding additional benefits. Such premium increases would unnecessarily jeopardize the viability of affordable supplemental insurance policies.

In conclusion, AFLAC believes that the continued availability of supplemental insurance should be encouraged in the state of Kansas. Therefore, we respectfully request that the following language, which has been recommended by the interim study committee and is found

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MARCH 4, 1999

in Senate Bills 3 and 14, should also be considered and recommended for inclusion in House Bill 2097:

> **The provisions of this section shall not apply to any policy or certificate providing coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care, as defined in K.S.A. 40-2227, and amendments thereto, medicare supplement, as defined by the commissioner of insurance by rules and regulations, vision care or other limited-benefit supplemental insurance, nor any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket, or individual basis.**

We believe these provisions provide a consistent definition and clarification of the coverages to which health insurance mandates should not apply. Again, thank you for your time and consideration.

Respectfully,

David A. Hanson

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March 4, 1999
Steve Richardson
House Bill No. 2097

On February 4, 1977 I received a spinal cord injury when I was run over by a car while employed by Yellow Cab. I walked with a bad limp using a cane from injuries to my left knee, leg and back. I had two surgeries on my knee and leg and severe pain in my back. The later part of 1977 I began suffering problems with my bladder and muscle spasms throughout my body.

The doctors did not know what was causing the problems with my bladder and the muscle spasms so I entered the hospital for tests. They found I was showing symptoms of Multiple Sclerosis. That was when my world turned upside down. They also found vertebras in my back were pressing against a nerve. This injury was caused by the pressure from walking on one side with a cane due to my accident. I went from a cane to a walker and then a walker to a wheelchair as my legs became weaker and I lost mobility. My disease (Multiple Sclerosis) has progressed steadily since then.

I paid for my first manual wheelchair myself because I did not have any insurance. That chair only lasted three years. The second wheelchair was partly paid for by Medicare and I paid for the remainder. Medicare would not pay for repairs to the wheelchair. The repairs cost so much that I had to weld the chair back together myself. The wheelchair literally fell apart and I had to put it back together. A wheelchair goes through a lot of abuse. For example, when A & A Services, a company that specializes in transporting people with disabilities, came to pick me up, damages would occur such as bent wheels and broken leg rests.

Medicare will only pay for certain wheelchairs. I am a big man and wheelchairs paid by Medicare would not fit me. Medicare wheelchairs are cheaply made and do not last long. Medicare will only pay for a wheelchair once every five years. This is not enough, as wheelchairs last only about two or three years and changes in medical condition are not taken into consideration when replacement needs occur.

I used a manual wheelchair from 1978 to 1996. I could not pay for an electric wheelchair when my income consisted of $477 per month, out of which I had to pay for rent, utilities, medical supplies, food and everything else I needed. I went without medical supplies, food and many times had my utilities cut off because I simply could not pay for them. I began experiencing numbness and pain in my neck and right arm from pushing myself in my manual wheelchair. After entering the workplace in 1995, I received an electric wheelchair, paid for by Kansas Vocational Rehabilitation in 1996.

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I only have private insurance Blue Cross (Blue Select) now. I had a waiting period of 247 days when I took out Blue Select because of my pre-existing condition. During that time they would not pay for my medicine or anything. Blue Select will not pay for any repairs to the wheelchair that Kansas Vocational Rehabilitation bought. I have to pay for repairs to my electric wheelchair. Some doctors will not even take Blue Select. Medicare pays nothing now.

I feel private insurance (Blue Cross) should pay for repairs to my electric wheelchair or give some kind of benefit for durable medical equipment for the disabled. An electric wheelchair is necessary for mobility to some people with disabilities. Blue Cross (Blue Select) will only pay half of my doctor's bills, half of surgery bills, half of hospital bills, which puts those with disabilities in a situation when you have to have your wheelchair repaired or replaced. Private insurance premiums are getting higher while the quality of service is getting less.

Steve Richardson
Topeka Independent Living Resources Center
501 S.W. Jackson
Topeka, Kansas 66603

Testimony in favor of passage of House Bill No. 2097

I wish to testify in favor of House Bill No. 2097. This bill is necessary for the following reasons:

1. To recognize that Durable Medical Equipment is a necessary complement to the medical care required by individuals with disabilities.

2. To ensure persons with disabilities are provided opportunities to reach full potential without the encumbrance of low coverage limits.

3. To help defray some of the costs associated within an adaptive environment.

My family and I are new residents of the State of Kansas. I accepted an offer of employment with the City of Topeka after exiting the Military during the fall of 1998. Upon review of the medical coverage limits I was disappointed in the low limit of coverage for durable medical equipment. Our son Andrew, who is 4 now, was born prematurely and has cerebral palsy - a nerve and muscular disorder. At age 3 Andrew was showing signs of improved upper torso strength and control although the spasticity in his legs did not allow for upright mobility - nor do they today. It was agreed by the therapists to try Andrew in a power wheelchair since he did have good control over his left arm and could control a joy stick for movement. The first minutes during the trial brought tears to all our eyes as we watched our son for the first time become mobile.

I am thankful that we were still in the military when Andrew was 3 and that the total cost of his power wheelchair was covered - $8,500.00. Even though this cost was covered there were several items which we still had to fund out of our own pocket. At the time we did not have a vehicle where a power lift could be installed. We purchased a new Dodge Van and outfitted it with a Braun lift - $22,000.00 and $4,000.00 respectively.

Upon arrival in Topeka, we were limited in our housing choices to single story due to safety concerns of stairs. As many of you are aware, your choice of non-basement homes in tornado alley are limited. In addition, we must install ramps, and ensure hallway widths and bathrooms can accommodate our son's requirements.

I am sharing the above to illustrate that costs required to integrate individuals with disabilities can be extensive and do not end with the durable medical equipment. As a minimum, this necessary equipment should be covered and I urge you to approve the House Bill before you.

Very respectfully submitted,

Mark Green

Mark Green
2724 SW Burnett Road
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attachment # 20
March 4, 1999

HOUSE COMMITTEE ON INSURANCE

HOUSE BILL **2097**

DURABLE MEDICAL EQUIPMENT

I am a hard of hearing person. I wear two hearing aids. Without these aids I would not be able to hold my job or function well in my community.

I work in the rural areas and I have seen first hand the lack of medical equipment that is needed. It is impossible for older folks to get glasses, teeth and hearing aids, which are the basic needs in the older age group.

There are young families struggling to meet their child's needs for medical equipment. After brain surgery, I was given a limited time for therapy and I was not allowed to get the needed equipment I requested for a faster recovery. All I received was a walker and cane.

Somebody asked me how this would be paid for. We all, those that are insured, are paying premiums and have for years. That is what they are for. So when services are needed we don't have to fight insurance companies for those services.[1]

I heard some owners of businesses ask you not to support this bill. They say the cost will be too high. Won't the cost be to high with a employee who gets hurt and could return to work if they could get help with medical equipment?

---

[1] I had to fight my insurance company to get my needed brain surgery to remove a cancerous brain tumor.

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Won't the business get better employees who will stay longer with a good insurance plan? The first two questions an applicant asks is, 'What is the pay' an 'What type of insurance do you have.'

I ask you to support House Bill 2097. It's just the right thing to do. And it just makes good sense. Thank you.

Roger Harsh

Roger Harsh
23915 235th St.
McLouth, KS, 66054

Choices & resources for people who are blind or low vision

Envision®

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March 1, 1999

TO: House Insurance Committee

SUBJECT: SUPPORT FOR HOUSE BILL 2097: Durable Medical Equipment Coverage Requirements for Kansas Insurance

I am sure that sometimes you, who are in the Legislature, feel that you are being asked for the moon, the world, and everything else by certain special interests, and all of it is being requested at the expense of the Kansas tax payer, or at the general expense of your constituents, in terms of cost of living, etc. The insurance industry representatives have certainly characterized the debate over what should and should not be covered under the definition of DURABLE MEDICAL EQUIPMENT, the extent of coverage, and the frequency of coverage, in this light. They have attempted to make you think that we who are disabled want luxuries in life, and that insurance costs would sky-rocket if durable medical equipment coverage were to be increased. the industry would have you believe that the intent of the disabled community is to have a Jacuzzi on every sun porch and a new motorized pleasure palace every year. That is what they are likely to tell you we are requesting via House Bill 2097. <u>SUCH CHARACTERIZATIONS ARE NEITHER FAIR OR ACCURATE.</u>

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Attachment # 22

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There are really two issues involved:

1. How often should individuals be able to get durable medical equipment coverage and how much money should be the maximum spent by insurance each time?

and

2. What should be defined or included as DURABLE MEDICAL EQUIPMENT?

House Bill 2097 addresses both issues in a positive light, but I will spend more of my time and effort on the second issue than the first. For people who are blind and visually impaired, so little of what they need is covered that the first issue is meaningless unless the second is addressed.

As to the first issue, however, it is frankly a considerable hassle to have to always be breaking in new equipment. Extremely few people are going to want a sleek, new, power wheelchair, for example, every year simply because their insurance may allow $10,000.00 each year to get one IF NECESSARY. For one thing, where ever the amount is capped, it is a virtual certainty that persons who need the equipment will have to spend some money out of pocket each time it is provided. We are simply talking, in many cases, about whether it is possible to get the equipment at all.

As to the second issue, however, I want to make it clear, on behalf of the primary population I represent, persons who are blind and visually impaired, that much of the equipment we need to live and work independently is not defined as durable medical equipment at all. There is largely currently no insurance coverage for it whatsoever.

This brings me to an amendment which I feel would provide additional clarification concerning the definition of DURABLE MEDICAL EQUIPMENT in 2097. I believe that in the examples section, on line 41 of page one, the term "electronic or computer assisted reading machines" should be added after the word "CCTVs" and before the word "hearing." This example would simply help document that reading machines to assist people who are totally blind in reading are covered in addition to CCTVs (which are reading machines designed to assist persons who have extremely low amounts of residual vision in reading.

The following are some examples of the extreme discrimination which currently occurs with regard to people who are blind and visually impaired and the equipment they need, even as compared with other disability groups. For the blind and visually impaired population, the definition of durable medical equipment thus becomes extremely important.

If an individual loses a leg, current definitions of durable medical equipment will allow the person to obtain a prosthetic leg which will not only appear to be a leg, but will, to some degree return the function of standing, and perhaps the function of walking, to the individual. If an individual loses their eyes, however, current definitions of durable medical equipment will allow for the purchase of prosthetic eyes which will make the person appear more pleasing to society, but those prosthetic eyes do absolutely nothing to RESTORE FUNCTIONS which have been lost to the individual due to not seeing. The prosthetic eyes will not read mail. They will not tell the person whether their clothes are colors which match. They will not allow the person to receive information about their environment so they can walk down the street independently, take a bus, go to work, do shopping independently, etc. Well proven devices are on the market which can help the blind or visually impaired person regain all of these FUNCTIONS lost when vision is lost, but there is no insurance coverage for any of this equipment. It is not even defined as durable medical equipment.

The problem seems to be that most definitions of durable medical equipment in some way require that the doo-dad or gadget gets hooked to the individual's body, or that they press their body up against it. This is the case with the prosthetic leg, the power or manual wheelchair, the bed lift, etc.

I, personally, can not see well enough to use a regular computer screen, at least, my visual correction does not allow me the stamina to do so for very long. My wife is totally blind and can not see a computer screen at all. Yet we both are employed. We both make shopping lists; we generally have the functions of literacy. We have these functions, however, because we are in debt up to our not-so functional eyeballs because we have had to pay out of pocket for all of the devices which allow our computers to talk and to display information in large print. Our computers are out of date and not in any way state-of-the-art; they are wearing out and need service, but because of all of the adaptations we have had to make to them, they are still not paid for. My wife and I live in the typical $50,000.00 house. We are paying for it in installments as do most people who own houses. We also own around $50,000.00 dollars worth of adaptive equipment to help me see things I would not see otherwise, and to help my wife be functional without seeing at all. Here is the real catch though. We are still making payments on the adaptive equipment as well; we are doing so at much higher interest than is available on our house, and none of the equipment can be expected to last as long as our house. The impact of House Bill 2097 would not keep us from spending money on such things, but it would allow some insurance co-payment so that being disabled does not end up costing us as much as it cost us to have a roof over our heads.

Envision also works with people who are deafblind, or dual sensory impaired (both visually and hearing impaired) We thus must point out that many programmable hearing aids and assistive listening devices experience the same lack of coverage as durable medical equipment as do devices which convert print to speech, print to Braille, make computers talk, or enlarge print to up to 60 times its original size.

There are devices which allow a person who has Ushers Syndrome (extremely narrow visual fields due to retinitis pigmentosa coupled with moderate to total loss of hearing) to travel in crowded areas without running into people, walls, protruding objects, etc. on their sides, and which they will not see. Such devices are absolutely not defined as durable medical equipment and are not covered by most insurance. Yet Medicade, and some private insurance as well, does cover the ongoing expense in some cases for such individuals to have attendant care to help them get from place to place and meet their basic needs. Having the device might not completely negate the need for the personal assistance, but it would certainly help reduce the amount of hours. The insurance industry keeps telling you how much it would cost to cover part of the durable medical equipment requests for people who need such coverage. They fail to mention, however, the costs connected with not covering such equipment.

The bottom line is that any definition of durable medical equipment used must relate to the restoration of function lost through physical, sensory, or cognitive disabilities. Such definitions can not be predicated on whether one

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hooks the equipment to the body or not. To do so is to discriminate mightily against the sensory and cognitively impaired.

Now I have admitted that the stuff blind and low vision people use costs a lot of money. The insurance industry may thus be saying, "That's right! You may need it but we still can not afford it and are not going to do it." The response is quite simple; because we have gone into more debt for durable medical equipment than we have for our house, my wife and I are both employed. We pay a good deal of taxes. I can assure you that without the durable medical equipment we use, our income would not be a tenth of what it is by having the stuff. We would need a certain amount of personal assistance, some of which would be covered by insurance, where with the equipment, we need none. The response from the industry may be that all of this is wonderful and that we are an example of why coverage is not needed; people can buy the stuff themselves. The response is to ask all of you on the Committee, if a new medical condition or disability were to come upon you, could you afford equipment more expensive than your house to deal with it. If the answer is "yes," you are very lucky, but also very unusual.

In conclusion, there does need to be mandatory coverage for durable medical equipment. It needs to be a significant, capitated amount available each year. The $10,000.00 proposed in 2097 would be a good starting point.

We have been told that this hearing is largely informational, that you all really do not plan to do anything with this issue this year. While it is not surprising that this is turning out to be a multi-year Legislative issue, I would ask that you not make disabled people wait for ever. I would ask you to not for ever give lip service to the concerns while continuing to relegate people with disabilities to a second class citizenship simply because they are unable to get the doo-dads and gadgets they need to be competitive with those who are non-disabled. Thank you for your consideration of these matters.

STATE OF KANSAS
DEPARTMENT OF HUMAN RESOURCES
Bill Graves, Governor
Wayne L. Franklin, Secretary

COMMISSION ON DISABILITY CONCERNS
1430 S.W. Topeka Boulevard, Topeka, Kansas 66612-1877
Voice: (785) 296-1722 • TTY: (785) 296-5044 • Fax: (785) 296-0466
Toll Free: (Outside Topeka) 1-800-295-5232

Testimony in Support of HB 2097 for
The Kansas Commission on Disability Concerns
Given by Sharon Huffman, Legislative Liaison
March 4, 1999
Before the House Insurance Committee

The Kansas Commission on Disability Concerns (KCDC) was established by Kansas law nearly 50 years ago to carry on a continuing program to promote a higher quality of life for people with disabilities. One of our responsibilities is to submit recommendations to the legislature believed necessary to promote the independence of people with disabilities.

KCDC regularly conducts town hall meetings throughout the state in cooperation with Kansas Rehabilitation Services (KRS). These meetings are held in all regions of the state and draw crowds representing all different disabilities and income levels. Most of the people who attend the meetings are either individuals with disabilities or friends and family of individuals with disabilities.

The issues addressed have varied slightly from year to year, but one of the major issues that surfaces each year is the need for increased funding for services that will allow individuals to live in the community. Although HB 2097 is not asking for actual funding of community services for people with disabilities it would be, in a sense, privatizing some of the services currently being provided to state and federal dollars. Rather than the State Rehabilitation Services (SRS) purchasing durable medical equipment (DME) for those who are in receipt of private insurance benefits, it should be the insurance company paying for the equipment.

Many times the only thing keeping a person from returning home from the hospital, nursing home or state institution is the inability to purchase the durable medical equipment necessary to maintain their independence. For instance, if a person has lost the use of their legs they must have a wheelchair in order to get around in their home and community. The current low caps on durable medical equipment make it difficult, if not impossible for some individuals to purchase the proper equipment to meet their needs.

KCDC urges your support of this bill and asks that you pass it favorably out of this committee.

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Community Action, Inc.

Testimony Presented to the House Committee on Insurance
Regarding Housing Bill No. 2097
March 4, 1999

I am Donna Stevenson, Community Services Director with Community Action, Inc., and I am presenting this written testimony in favor of HB 2097, which will; establish a minimum that health insurance companies must pay annually per individual for Durable Medical Equipment (DME); define DME more broadly; and provide power equipment when appropriate.

Community Action is particularly interested in this bill because it has a direct impact on the low-income clients we serve in Shawnee and Wabaunsee Counties through our Medical Equipment and Supply Loan Program. We began this program in 1996 to specifically address the lack of adequate coverage for prescribed Durable Medical Equipment.

We are supportive of this bill because it addresses maintaining personal independence and lowering health care costs related to unnecessary hospital nursing home stays. These are issues that are very important to voters as found through the Survey of Kansas Seniors administered by Kansas Department on Aging. These issues are also very important to the state from an economic standpoint as presented by the Public Assistance Coalition of Kansas.

During 1997, the Kansas Department on Aging surveyed 3,220 seniors across the state. They were asked to identify any of the 25 concerns listed which they "...believed would be a concern to them within the next five years." Their responses reflected that *"Maintaining personal independence"* and *"Expense of medication and medical supplies"* were ranked, by importance, one and two respectively. When those same seniors were asked to identify three of the concerns selected in the above question that "...needed addressed first by providers," the answers and their ranking of importance were the same – *"Maintaining personal independence"* and *"Expense of medication and medical supplies"*.

1000 S.E. Hancock • Topeka, Kansas 66607-1578 • (913) 235-9561

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The Public Assistance Coalition of Kansas has reported that the cost to SRS in 1994 for nursing home care averaged slightly over $16,000 per year per person – a total of $225 million for 14,000 nursing home residents. From an economic standpoint alone, it makes sense to enable our citizens (young and old) to remain in their homes for as long as possible. Additionally, maintaining personal independence also positively impacts upon such issues as productivity and quality of life.

It has been our working experience at Community Action that in many situations, the only barrier between maintaining personal independence and incurring costs related to hospital and nursing home stays is the unexpected expense of less costly durable medical goods such as shower chairs and stool risers. The clients we have served through our Medical Equipment & Supply Loan Program have lacked the necessary resources to obtain prescribed durable medical equipment. Government programs and private insurers limit coverage for such aforementioned items that make a difference between independent living and unnecessary hospital and nursing home stays. Many seniors are puzzled by this lack of coverage since they've paid insurance premiums for, in some cases, as long as 60 years.

HB 2097 would allow citizens the ability to maintain personal independence, remain productive within their communities, and limit costly hospital and nursing home stays by providing better coverage for prescribed durable medical equipment that costs significantly less. It is obvious that insurance companies, the State of Kansas, taxpayers, and voters will benefit economically with its passage.

FamiliesTogether, Inc.

Parent Training & Information Centers for Kansas

Home Page:
http//www.kansas.net/~family

Wichita Parent &
Administrative Center
3340 W Douglas, Suite 102
Wichita, KS 67203
Voice (316) 945-7747
1-888-815-6364
Fax (316) 945-7795
e-mail: fmin@feist.com

Topeka Parent Center
501 Jackson, Suite 400
Topeka, KS 66603
Voice/TDD (785) 233-4777
1-800-264-6343
Fax (785) 233-4787
e-mail: family@inlandnet.net

Garden City Parent Center
111 Grant
Garden City, KS 67846
Voice/TDD (316) 276-6364
1-888-820-6364
Español (316) 276-2380
Fax (316) 276-3488
e-mail: famtogether@pop.gcnet.com

Kansas City Parent Center
6333 Long, Suite 230
Shawnee, KS 66216
Voice (913) 962-9657
Fax (913) 962-9690
e-mail: kcfam@kc.net

Statewide Spanish Parent Line
1-800-499-9443 (Español)

Date: March 4, 1999

To: House Committee on Insurance

From: Bonni Pennie, Families Together, Inc.

Re: HB 2097

My name is Bonni Pennie. My husband and I have three daughters: Stephanie, 15, Valerie, 12, and Emilie, 9. Stephanie and Emilie both have a severe to profound hearing loss.

I represent Families Together, Inc., the statewide Parent Training and Information Center for Kansas parents and their sons and daughters with disabilities. We have four centers in Kansas (Wichita, Topeka, Garden City and Kansas City). The majority of our staff are parents or family members of young people with disabilities.

We are asking that you give careful consideration to HB 2097. Durable medical equipment, like other forms of assistive technology, can mean a world of difference for a person with a disability. It can often open the door to independence. In the case of my two daughters, the hearing aids they wear allow them to interact with their peers, teachers, family and friends. Without their hearing aids, they would not be

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able to communicate with others except through an interpreter.

Families that we talk to every day agree that durable medical equipment such as wheelchairs, hearing aids, and low vision devices provide needed independence but can often be quite costly.

When Emilie was first diagnosed, Stephanie was also in need of replacement hearing aids. Within a one month period, our family needed to purchase four hearing aids at a total cost in 1991 of $2400. We had good insurance that we paid monthly premiums on, but it offered no assistance for durable medical equipment. We were forced to seek outside assistance as well as spreading out the purchases over a period of time. Possibly some of this cost could be absorbed by private insurance as well as public programs.

Families Together would ask that you consider the increased independence that durable medical equipment can provide for individuals, the cost involved and the role of the insurance companies. We ask for your support for HB 2097.

Testimony in Favor of House Bill No. 2097
Jan Naegele
March 4, 1999

My name is Jan Naegele. My daughter, Lindsay, has had Cerebral Palsy since birth due to a traumatic labor/delivery. My ex-husband and I both work and have carried health insurance as long as we can remember.

I am submitting written testimony because of our extensive experience over the years with Durable Medical Equipment and health insurance.

First of all, I'd like to clarify that Lindsay is quite a healthy girl. She has yet to be admitted to the hospital since birth other than a test that lasted less than a day. She is normal to above normal cognitively. Due to her Cerebral Palsy, she is non-verbal and has physical difficulties necessitating types of DME to allow for mobility and physical therapy and function in daily living – such as bathing and toileting and also to help prevent physical deformities and health problems related to the affects of Cerebral Palsy.

The struggles and challenges in life with a disability are enormous. Generally, we have no time to spend on any one issue or we find they pile up. But, we as parents feel it is important you are aware of what we go through as we have found many people have no idea. Finding out you have a loved one with asymmetrical upper body control problems, which necessitates using a power wheelchair, and then finding your health insurance policy has written this medically necessary equipment out of their policy and will only allow the price on a non-power chair, which may be a fraction of the cost of the power unit, may prove quite a difficulty for your family. You most likely, as we did, know where the priorities lie in the needs of your child. Thus, you will find yourselves borrowing endless amounts of money to pay for DME, which is a medical need, and what we always thought we carried health insurance to pay for.

I'd like to give a few examples of our experience—
(Some of the dates and amounts are approximations, as I did not take the time to retrieve all our records.)
Lindsay's first power wheelchair was purchased in 1989-90. To our disbelief, the power wheelchair was written out of our health insurance policy -- Thus our health insurance responded stating they would pay the price of a nonpower wheelchair. The price quoted by the health insurance company they would allow for the nonpower wheelchair was "way low" according to Lindsay's Physical Therapist at the time. Thus I wrote to the Insurance Commissioner who agreed and the health ins. co. increased their allotment for the nonpower wheelchair slightly, after which we approached a few agencies regarding funding – found one agency who offered $1000.00 toward the power wheelchair and were humiliated by another who told us we needed to be poverty level to expect funds from them – Henceforth, my then husband and I decided to make payments on the

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remaining balance which was around $4000.00 and became wary of approaching agencies for funding in the future.

Our next purchase was Lindsay's epson communication device. The price was around $5,400.00 – The health insurance company denied coverage. We approached the one agency we had faith in – They again offered $1000.00 toward the cost of the device – Thus we borrowed the remaining approx. $4,400.00

At this point a fellow Hays resident, caring for his disabled loved one, approached my father and said to tell us not to even try – meaning to keep up financially because as he said "it will take you down – there is no way to keep your head above water."

Lindsay was ready for an updated communication device around 2 years ago. We did not submit this one as we were certain it again would be denied.

As a family before our divorce in 1993, we purchased a full sized van out of necessity to transport the wheelchair – which we certainly would not have purchased if not out of necessity.

Our latest dealing with health insurance was the purchase of Lindsay's current power wheelchair July 8th of 1997. The total cost of the power wheelchair was $10,796.98. We as a family were required by the provider to pay approx. 50% of the total cost up front before the provider would order the power wheelchair – so we borrowed $5000.00. Our health insurance company had written power wheelchairs out of their policy – thus allowed $817.08 which was their allowance for the price of a non-power wheelchair. Our health insurance co. allowed $920.00 for the power tilt on the wheelchair which allows Lindsay to tilt the wheelchair to help prevent pressure sores and skin breakdown. Once again left with an enormous balance of $9,059.00 either to pay ourselves or start phoning agencies looking for funding. This time the same agency who in the past offered $1,000.00 to help with equipment offered $5000.00 which was a wonderful substantial amount. Thus leaving us as a family with a balance of $3,816.80.

My goal in submitting my testimony is to make you aware of some of the things we go through due to health insurance companies being allowed to "write out" certain DME from their policies. My hope would be that medically necessary Durable Medical Equipment such as the power wheelchair be covered by health insurance coverage so that we, as many of you who carry health insurance, could begin to meet our children's health care needs through our health insurance.

Written Testimony
HB 2097
Presented by: Brenda Eddy

Mr. Chair and Members of the Committee:

Thank you for the opportunity to testify in support of HB 2097. I have long been waiting for the day when I could speak out on behalf of getting hearing aids covered under basic insurance plans.

My name is Brenda Eddy, I have been hearing impaired since birth. I have worn hearing aids since I was four years old. I was born into a family where three of us needed hearing aids. My dad was a farmer and rural mail carrier. My mom worked at various jobs to supplement dad's income. Keeping hearing aids on three family members was a tremendous financial hardship – even back when hearing aids were only $200 dollars. Hearing aids were never covered under any of my parent's insurance policies, nor have they been covered under any of my health plans prior to my current employment.

My current policy pays 80 percent of a one-time purchase of hearing aids. For this, I'm appreciative. However, most of us serious hearing aid users buy hearing aids about every five years due to rapidly changing (and improving) technology. My last set of hearing aids cost $3,000. I could only afford them five years ago because my mother-in-law paid for them. I'm due for a new set soon but I've been putting off buying them because my 20 percent co-pay will be $800.

Like my parents before me, I have worked hard all my life to be a contributor to society. My hearing aids are the determining factor in how well I function in the mainstream. Hearing aids are a medical necessity for me – not a luxury item. Insurance coverage for hearing aids is long, long overdue.

Please support this bill.

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Statewide Independent Living Council of Kansas **SILCK**

700 S.W. Jackson, Suite 212, Topeka, KS 66603 ☎ (785) 234-6990 voice / TDD ☎ (785) 234-6651 fax

Testimony Presented to
House Insurance Committee
by Shannon Jones
March 4, 1999

I am Shannon Jones, the executive director if the Statewide Independent Living Council of Kansas (SILCK). The SILCK is mandated by federal law, the Rehabilitation Act as amended in 1998 to study existing services for people with disabilities and make recommendations to improve and expand services that will enable Kansans with disabilities to achieve their optimum level of independence and improve their quality of life.

The SILCK supports HB 2097. This bill will definitely address the concerns the Council hears from the constituency we represent, Kansans with disabilities. Every year the Council conducts public hearings across the state to find out what barriers remain in Kansas for people with disabilities to live independent lives.

Time after time the SILCK receives comments regarding the lack of adequate insurance coverage for Durable Medical Equipment (DME).

Often times people with severe limitations due to their disability need certain types of equipment that will allow them to maintain their jobs and their independence. However, private insurance companies frequently avoid paying for DME by establishing annual policy limits on DME per beneficiary, narrowing the definition of DME, and refusing to cover power equipment. Inadequate DME coverage can lead to increased physical deterioration and dependence on other caregivers.

This can sometimes lead to nursing home placement, in which case the cost is much higher that the one time cost of the equipment necessary for the individual to remain in their own home and improve their independence.

The SILCK urges this committee to support HB 2097.

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WHEELS FOR FREEDOM INC.
P.O. BOX 12222, KANSAS CITY, KANSAS 66112 • 913-722-3832

February 26. 1999

Mary Ellen O'Brien Wright
Funding and Policy Specialist
Assistive Technology for Kansans
501 S.W. Jackson, Suite 450
Topeka, Kansas 66603

Dear Ms. Wright,

I am writing you at this time in behalf of Wheels for Freedom to support House Bill No. 2097 which would provide coverage for durable medical equipment. This is an important bill for the people of Kansas who are physically disabled; it is also important for their families who are responsible for them. Many insurance companies have not provided enough coverage or none at all for the purchase of motorized wheelchairs for their clients.

Wheels for Freedom came into existence in 1987, to help provide powered mobility for those needy and disabled students in the Kansas City, Kansas School District. Throughout the last twelve years, the organization has also helped students in the Turner and Shawnee-Mission school districts. Wheels recognized the need to make up for insurance deductibles, provide complete coverage for the wheelchairs which were not covered by policies, and combine coverage with insurance, Muscular Dystrophy Association and other funding sources.

Wheels for Freedom believes that the insurance companies need to change their guidelines regarding the coverage of disabled persons in regard to the purchase of motorized wheelchairs. They need to give "power" to the physically challenged.

Sincerely,

Barbara Wetzler

Barbara Wetzler
Public Relations Chairman-Wheels for Freedom

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Kansas Association of
KACIL
Centers for Independent Living

Gina McDonald
Executive Director

Member Agencies:

ILC of
Southcentral Kansas
Wichita, KS
316/942-6300 Voice/TT

Independence, Inc.
Lawrence, KS
913/841-0333 Voice
913/841-1046 TT

Independent Connection
Salina, KS
913/827-9383 Voice/TT

LINK, Inc.
Hays, KS
913/625-6942 Voice/TT

The WHOLE PERSON, Inc.
Kansas City, MO
816/561-0304 Voice
816/531-7749 TT

Topeka Independent
Living Resource Center
Topeka, KS
913/233-4572 V/TT

Southeast Kansas
Independent Living, Inc.
Parsons, KS
316/421-5502 Voice
316/421-6551 TT

Accessing Southwest
Kansas (ASK), Inc.
Dodge City, KS
316/225-6070 Voice/TT
1-800/871-0297

March 4, 1999

Kansas Association of Centers for Independent Living, Inc. (KACIL) is in support of House Bill 2097. We represent Kansans with disabilities that need and want to live as independently as possible. Certain types of Durable Medical Equipment are crucial to daily living for many people with disabilities. Power wheelchairs and augmentative communication devices can make independent living possible. Independent living is less expensive than other institutionalized care.

The cost of many Durable Medical Equipment items is too expensive for many Americans to pay for out of pocket. Many people, who pay expensive insurance premiums are denied coverage for power wheelchairs, visual and hearing needs and other necessary devices that could enable them to live and work productively. To live and work as independently as possible is what we all want. It is time to become enlightened to how much assistive technology can help people with all kinds of disabilities. The economic advantage is too valuable to ignor any longer. Everyone wins when modern technology helps people help themselves.

Kansans who have been paying health insurance premiums to insurance companies for years are denied coverage to power wheelchairs and other physically necessary assistive devices that would enable them to do the basic functions in life. The basic functions that many of us take for granted.

KACIL asks for your support in favor of House Bill 2097. Thank you for allowing me to provide this written testimony. If you have any questions, please feel free to contact me.

Gina McDonald, Executive Director
Kansas Association of Centers for Independent Living
1423 West Crawford
Salina, Kansas 67401
(785) 825-2675 V/TT
(785) 825-7029 FAX

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501 Jackson, Suite 450 · Topeka, KS 66603 · 913/233-4550 (Voice/TT) · 913/233-4231 (FAX)

March 4, 1999

To Whom It May Concern:

Please allow us to introduce ourselves. We are Steve and Kristin Cooper from Wichita. We are writing to you to solicit your support for House Bill 2097. While we are confident that the passage of Bill 2097 would provide a tremendous financial relief to the many citizens of Kansas facing various mental and physical disabilities, we can only testify about how it would positively effect our family.

On April 19, 1995, our daughter Karlee was born missing her right hand and the majority of her right forearm. There is no medical explanation for her particular condition, it is simply termed a "failure of formation." Obviously we had many questions concerning Karlee's future; Would she be able to function independently? How would she be accepted by her peers? What could we do to help? You only need to quickly review your daily activities and how many require the use of two hands to understand how serious our fears were.

After several months of researching different options in prosthetics, we learned about a device called a myoelectric hand. It consists of a motorized hand mounted to a synthetic forearm which opens and closes by sensing muscle contractions in the remaining limb and converting that impulse into an electric signal. When introduced early enough, it is actually easier for a child to learn to operate than a conventional "hook" prosthesis, and it looks very much like a real hand. The realistic appearance can be a great boost to the child's body image and self-esteem, and the functionality provides for a more seamless transition into the "two-handed" world we all live in. The one drawback? Cost.

According to our research, a typical myoelectric prosthesis for a child with a below elbow limb deficiency can cost between $8,000 to $25,000, depending on the provider. As the child grows, the prosthesis will need to be adjusted and modified for growth periodically and then replaced entirely – approximately every 2-3 years. These adjustments and modifications alone can amount to several thousand dollars, which is in addition to the original cost of the prosthesis.

Unfortunately, most insurance policies, like our own, will only provide for only one prosthesis per lifetime. This condition is completely unrealistic for even an adult, much less a growing child. This would be like asking a person to go their entire life wearing the same pair of glasses. Only a new pair of glasses are only a fraction of the cost of a myoelectric. Compounding the problem is the fact that there are no agencies or foundations in the state of Kansas that specifically help families of children with limb deficiencies. We were referred to the Shriner's hospital in St. Louis, but after meeting with them, were told that they would not be able to meet our needs. And very few families have the financial resources to pay for these ongoing expenses on their own.

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Fortunately, through our own resources as well as several generous one-time gifts, we were able to purchase Karlee's first myoelectric two years ago. We are happy to report that she is now able to perform most of the same two-handed activities as her peers, and her frequency of use and proficiency are improving each day. Without her myoelectric (or Powerhand, as we like to call it), Karlee either can't perform some tasks, or takes much longer to accomplish them –sometimes giving up our of sheer frustration. She recognizes what a help it is to her, asking us to put it on her in the morning.

But we have no assurance that the necessary resources will be available when Karlee's myoelectric needs to be replaced soon. We have already used the one prosthesis allowed by our insurance company when we obtained a preparatory "passive" hand about a year before the purchase of her myoelectric. And since they are under no contractual obligation to do so, there is little hope our insurance company will provide for any of Karlee's future prosthetic needs.

Only by the passage of House Bill 2097 will we have the peace of mind of knowing that Karlee will have the prosthetics necessary to help her become a confident, productive member of society. We support Bill 2097 and strongly urge those involved to vote in its favor. Thank you.

Steve and Kristen Cooper
1424 N. Westfield Ct.
Wichita, Kansas 67212
(316) 722-5882