Approved: March 27, 2003
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Stephen Morris at 10:35 a.m. on March 5, 2003, in Room 123-S, of the Capitol.

All members were present except: Senator David Adkins - excused
Senator Christine Downey - excused
Senator Larry Salmans - excused

Committee staff present:
Alan Conroy, Director, Kansas Legislative Research Department
J. G. Scott, Chief Fiscal Analyst, Kansas Legislative Research Department
Leah Robinson, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Debra Hollon, Kansas Legislative Research Department
Audrey Nogle, Kansas Legislative Research Department
Robert Waller, Kansas Legislative Research Department
Michael Corrigan, Assistant Revisor of Statutes
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Senator Bill Bunten
Art Anderson, Ombudsman, Division of Workers Compensation, Kansas Department of Human Resources
Scott Brunner, Acting Deputy Secretary of Operations, Kansas Department of Social and Rehabilitation Services
Dr. Michael Moser, Director of Health Services, Kansas Department of Health and Environment

Others attending: See attached list

Bill Introductions

Senator Feleciano moved, with a second by Senator Schodorf, to introduce a bill regarding the state finance council; voting procedures (3rs0398). Motion carried on a voice vote.

Senator Schodorf moved, with a second by Senator Bunten, to introduce a bill concerning repealing the Kansas performance review act (3rs400). Motion carried on a voice vote.

Senator Kerr moved, with a second by Senator Barone, to introduce a bill regarding transferring the functions of the office of state fire marshal to the board of fire services (3rs0885). Motion carried on a voice vote.

Chairman Morris opened the public hearing on:

SB 50–State employee voluntary leave purchase program

Staff briefed the committee on the bill.

Senator Bill Bunten testified regarding **SB 50** and explained that he had visited with a state employee, Art Anderson, Division of Workers Compensation, about an idea that he found interesting (Attachment 1). After visiting with others about the idea, Senator Bunten noted that he decided to introduce a bill that would, if passed, be beneficial to both state employees and the state. Portions of the bill were detailed.

Art Anderson, Ombudsman, Division of Workers Compensation, Kansas Department of Human Resources, testified in support of **SB 50** (Attachment 2). Mr. Anderson thanked the committee for the opportunity to present the idea that he felt would allow the State of Kansas to do two things that are very important to all:

- reduce the State payroll expense
- provide a morale-boosting benefit program

Mr. Anderson explained that he came across this idea due to his wife being employed several years with an international business, CIGNA Insurance, and also with another company, Kemper Insurance, and both companies have this program in place. Additional information was distributed to the committee by Mr. Anderson regarding CIGNA Corporation (Attachment 3) and Kemper Insurance (Attachment 4).

Chairman Morris recognized Jack Rickerson, Director, Division of Personnel Services, who mentioned that the Kansas Department of Administration was neutral on the bill but they were concerned with the fiscal impact. Committee questions and discussion followed. Chairman Morris requested amendments from the Agency regarding **SB 50** for committee discussion.

The Chairman closed the public hearing on **SB 50**.

Chairman Morris opened the public hearing on the following Federal Block Grants (notice of the hearing appeared in the February 6, 2003, issue of the Kansas Register):

Kansas Department of Social and Rehabilitation Services, presented by Scott Brunner, Acting Deputy of Operations (Attachment 5):

Social Services Block Grant (SSBG)
Block Grant for the Prevention and Treatment of Substance Abuse
Community Mental Health Services Block Grant
Low Income Home Energy Assistance Block Grant (LIHEAP)
Projects for Assistance in Transition from Homelessness Block Grant (PATH)

Kansas Department of Health and Environment, presented by Dr. Michael Moser, Director of Health (Attachment 6):

Preventive Health and Health Services Block Grant
Maternal and Child Health (MCH) Services Block Grant

Committee questions and discussion followed. Chairman Morris recognized Paul Johnson, Public Assistance Coalition, who expressed concern that in regard to the LIHEAP federal block grant, weatherization is vital and a longer term answer in helping people with utility bills. He hoped that the committee would consider mandating the 15 percent transfer out of the LIHEAP federal block grant to weatherization.

The Chairman closed the public hearing on the Federal Block Grants.

The meeting adjourned at 11:30 a.m. The next meeting is scheduled for March 6, 2003.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE March 5, 2003

NAME	REPRESENTING
Lisa Becker	SRS
Lois Weeks	SRS
Scott Brunow	SRS
Julia Thomas	DOB
~~Keith Haxton~~	~~SEAK~~
Jackie Rickerson	KOPS
Karen Watney	DofA/DPS
Michael Moser	KDHE
Linda Kraus	KDHE
Deb Williams	KDHE
Jamey Kieffer	KDHE
~~Art~~ Anderson	~~KDHR~~ State Employee
Paul Johnson	PACK
Doug Bowman	CCECOS
Andy Sanchez	
Don M Regan	S.E.A.K

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STATE OF KANSAS

SENATOR BILL BUNTEN

COMMITTEE ASSIGNMENTS:

Member: COMMERCE
EDUCATION
LEGISLATIVE POST AUDIT
WAYS AND MEANS

TESTIMONY
ON
SB 50

SENATE WAYS & MEANS
March 5, 2003

Mr. Chairman and members of the Committee:

Last fall I visited with Art Anderson, a state employee who works at the Division of Workers Compensation. Art is a Program Consultant 1 and his job is to advise injured employees, who are not familiar with the process of filing a Workers Compensation claim, on what to do.

Art told me about an idea he had that I found interesting. After talking with others about that idea I decided to introduce a bill that would, if passed, be beneficial to both state employees and the state.

Art's wife worked for the Aetna Insurance Company and this plan was available to their employees, and their employees liked it.

In SB50 the plan is referred to as the "State Employee Voluntary Leave Purchase Program," and its provisions are very simple.

First, on page 1 of the bill, the Director of Accounts and Reports is authorized to enter into a voluntary agreement with an employee to "defer and deduct" a portion of the employee's wages. Those deducted wages are deposited in a fund in the state treasury. Under rules and regulations established by the Secretary of Administrator, the state employee, after exhausting his accumulated annual leave, may, if his supervisor agrees, take up to 10 days of unpaid leave and during that time draw from his escrowed wage account so that a check continues to be received during his or her time away from work.

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Attachment 1

An example would be that a state employee's husband has been injured in an automobile accident and requires attention by his spouse upon his return home from the hospital. If the spouse has used up her annual leave, and if her employer agrees, she may take an additional ten days off to be with her husband, and will continue to receive a check from her previous deductions.

This is helpful to the employee in a time of need, and to the state because she is not receiving a check for the period of her absence and it's a savings in salaries and wages for the department where she works.

This is a voluntary program, but the math is interesting. If an average employee received $14.00 per hour, that would be $112.00 per day and $560.00 per week. If 5% of the states 40,000 workers used this program for an average of five days it would save the state $1,120,000 dollars plus some fringe benefits.

I believe it is a good idea that could be helpful to our state employees on occasion and I hope the bill will receive our serious consideration.

March 05, 2003

To: Senate Ways and Means Committee Chairperson and Committee members.

Re: Senate Bill No. 50

First of all I want to thank you for allowing me to present this idea which I believe would allow the State of Kansas to do primarily two things that are very important to us all.

1. **Reduce the State payroll expense.**
2. **Provide employee a morale boosting benefit program.**

I came across this idea due to my wife being employed several years with an International business. CIGNA Insurance. She is now in her 8th year with another International company, KEMPER Insurance. Both of these companies have this program in place. They do also have another option which I will briefly explain but that option would defeat our goal and therefore I would recommend that it not be considered. I will mention this in #6 below.

CIGNA and Kemper have graciously provided me with some printed information and while it does not in great detail explain everything needed to know it does allow you to see that it is a viable program, organized and controlled by the employer to a benefit for employee and employer. CIGNA authorities explained to me that they have approximately 36,000 employees and they show that an average of 16,000 (about 44%) are able to take advantage of the program. In a nutshell the idea of the plan is that the employer allows the employee to place themselves on a voluntary furlough. This is slightly sugar coated by describing it as being able to purchase a predetermined time period of additional vacation. The employee would designate during a sign up period that they would want to elect to have an additional one or two weeks of vacation during the following year. I would suggest to reap immediate benefits that the plan be implemented to become effective by the July 01, 2003 fiscal year rather than wait until January 2004). If you just look at the idea with these oversimplified statements.

1. Suppose an employee earns $52,000 per year in wages. That employee elects to "purchase" an additional one week of vacation. What that person has agreed to is that they will only work 51 weeks as a normal pay status and for the one week of "purchased" vacation they would not be paid by the State but by moneys set aside thru payroll deduction throughout the year. This would effectively reduce the State payroll to that employee by nearly 2%.
2. The money set aside could be done either on each of the 26 pay periods and would be pre-tax or it could be on the first two pay periods of each month, also pre-tax.
3. An employee in a Pay Grade 15 at a Step 6 would agree to have a withholding of approximately $17.25 per pay period if deducted only on the first two pay periods of the month. If deducted over all 26 pay periods it would amount approximately $15.92 per pay period.

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Attachment 2

4. Information I gathered in the FY 2002 Budget shows that 2% of our total salaries and wages (including all benefits) would amount to nearly $32 million dollars. Of course that would require 100 % participation. I believe this is an employee benefit option and from the many State workers I have visited with about this plan a very healthy percentage of employees would participate. Even with only 25% it could save approximately **Eight Million Dollars. A savings that could continue year in and year out.** My wife has nearly 20 years with the two above companies and each year selects this plan.
5. There are of course units and sections where due to shortage of manpower it could not be practiced but as with all leave it must be approved by supervision and management.
6. **This has to be a USE IT OR LOOSE IT PLAN!** The wording in this bill provides that it could only be used when all other leave is used. We would virtually have no takers. None of us want to have a zero balance. There may be family emergencies, illness that exceeds accumulated sick leave. Just for special needs, we must all try to hold some accumulated leave on our accounts. That requirement to zero out accumulated leave is used with CIGNA and KEMPER, only if an employee signs up to be able to SELL back unused leave. Due to the selling back it falls under IRS regulations to be used last. The State would not want to purchase leave back and so it must be a use it or loose it plan. The two companies mentioned do require the use of the "purchased vacation" first, unless the employee enters into the sell plan. This is just like the "Flexible Spending Accounts" administered by KANELECT for the payment of out of pocket Child Care or unreimbursed Medical expenses. We either use the amount set aside or loose it. It takes planning but I have yet to find an employee who lost their contracted donation. KANELECT has a grace period for the submission of the bills.
7. This plan should have a provision that would allow for a brief time extension to use the purchased time if it was not available during the contracted time period. That would be an extremely rare condition as the requirement that "purchased vacation" be used prior to any accumulated vacation time would prevent such a circumstance from occurring.
8. **Once the agreement is made between the employer and employee the savings would be fixed.**

Thank you for your attention and time. Are there any questions?

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Teague

Assistant Director, Disability and Time Off Benefits

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E-mail: lisa.teague@cigna.com

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Attachment 3

BUYING AND SELLING VACATION DAYS

If you are a *regular employee,* you may be eligible to buy or sell up to five days of vacation at the time of the Signature Benefits *annual enrollment* period with the following exceptions:

- Employees hired during the year are not eligible to buy or sell vacation days for the year in which they are hired .

Buying Vacation Days

You may buy up to five additional vacation days, in units of one full day, for the following *plan year* using *pre-tax* dollars deducted throughout the year from your paycheck. You may start using purchased vacation days as of the beginning of the *plan year* (although in some states you must sign a form to take these days in advance; check with your manager) and must use all bought vacation days during that year or lose them.

The cost of each additional vacation day is equal to your annual *eligible earnings* divided by 260. If your annual eligible earnings change during the course of the plan year, your payroll deduction for purchasing the vacation days will not change during that year.

Using Bought Vacation Days

When you take vacation days during the year, you must use the vacation days you bought after you use any regular vacation time you earn.

You may use bought vacation days in advance of actually "paying" for them in full. As with regular vacation days, however, if you terminate your employment before you have paid for all of the days you have already taken, you will have to pay CIGNA for the vacation advance. Your election to buy vacation days gives CIGNA authorization to deduct from your final paycheck the value of any days you have taken but have not paid for.

You accrue your bought vacation days over 26 pay periods.

Selling Vacation Days

You may sell up to five vacation days for the following plan year in units of one full day. The dollars you receive from selling vacation days are first applied to offset the cost of any Signature Benefits pre-tax benefits, such as medical and dental coverage. If you have vacation day dollars left over after you pay for your pre-tax benefits, the remaining dollars are added to your bi-weekly pay and are subject to federal, state, and local income taxes.

The value of each sold vacation day is equal to your annual eligible earnings divided by 260. If your eligible earnings change during the course of the plan year, the value of your sold vacation days will not change during that plan year. Once this value is calculated, it becomes effective on the first day of the plan year and remains in effect for that entire year.

If the value of your sold vacation days exceeds the cost of your other pretax

benefits, the excess is added to your paycheck in equal amounts throughout the plan year. Any payment for sold vacation days which is included in your paycheck is **fully taxable** as ordinary income in the year you receive payment.

You must sell vacation time in units of one full day. The value of each vacation day you sell is equal to one day's earning (your annual eligible earnings divided by 260).

For example, if your eligible earnings are $20,000 and you sell five vacation days, your bi-weekly pay will be increased by $14.79. Here is the calculation: $20,000 divided by 260 equals $76.92, the value of one vacation day; $76.92 times five day equals $384.60, the value of five vacation days; and $384.60 divided by 26 pay periods equals $14.79 per pay period.

Electing to Buy or Sell Vacation Days

If you choose to buy or sell vacation days, your election will stay in effect from one year to the next unless you change your election during the *annual enrollment period*. You will not be able to change the number of bought or sold vacation days during the year, even if you have a life status change. If you choose to buy days one year because of special travel plans, but do not need or want to buy additional days the following year, you must change yur election during the next annual enrollment period.

Benefits-eligible, part-time employees can buy or sell vacation time based on their average number of scheduled hours in a week (total hours per week divided by five). For example, assume an employee works 32 hours a week. Each "day" he/she buys or sells is 1/5 of his/her standard workweek or 6.5 hours (32 divided by 5). So, if a day is bought, 6.5 hours is being bought, not 8 hours. He/she must buy five "days" in order to have the 32-hour week off.

Employees who are on a compressed workweek schedule should also convert vacation "days" bought or sold into hours. For example, an employee who works four 10-hour days each week would have to purchase five vacation days to be able to buy a full week of vacation.

For full-time employees, vacation days are calculated according to an 8-hour schedule.

Bought vacation days must be scheduled like regular vacation days, and must be used during the *plan year* or are lost. You cannot carry bought vacation days over from one year to the next.

If Your Job Status Changes

If your job status changes, but you **remain eligible to buy or sell vacation days**, you may still take any available bought vacation days during the remainder of the plan year. The value of any vacation days you bought will continue to be deducted from your remaining paychecks. The value of any vacation days you sold will continue to be credited to you in your remaining paychecks for the calendar year.

If your job status changes, but you are **no longer eligible to buy or sell vacation days**, your deductions will stop as of the date of the change. You must use or be

paid for all bought vacation days that you have accrued but not taken.

If you are promoted to an officer-level position during a calendar year, you will receive a pro-rate share of your vacation accrual schedule.

If You Terminate Your Employment

If you have earned but not used bought vacation days when you terminate your employment, you will receive a lump-sum payment for those days. The payment will include any bought days you have fully paid for, but have not used. The value of any vacation days you have sold, and for which you have not yet been fully paid, will not be added to the payment.

CIGNA reserves the right to modify, suspend or terminate its vacation buy/sell policy at any time. Your coverage under this policy may be modified or terminated as a result of such change. Any modification or termination will not affect your rights to accrued benefits.

Questions?

Contact your supervisor or the HR Service Center at 1.800.551.3539 if you have any questions about our vacation buy/sell policy.

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Vacation Buying Plan

Overview

For those employees who would like more vacation time, the vacation buying plan allows you to buy up to five additional vacation days on a pre-tax basis through payroll deduction. This is a summary of the vacation buying plan Kemper offers eligible employees.

Eligibility

You are eligible to buy additional vacation time if you are a regular full-time employee. When buying vacation during annual enrollment, you must be an active employee as of the beginning of the plan year for which you are electing vacation buying.

For purposes of this plan, you are considered an active employee when you are actively at work performing your job duties, receiving salary continuation payments or Kemper military leave pay, or on a leave of absence of less than 10 working days.

Employees, upon their return to work from a leave of absence, are not eligible to purchase vacation for the current year. Eligibility is also subject to provisions outlined in the Benefit basics section.

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Attachment 4

Buying vacation days

Under the plan, you may purchase up to five additional vacation days with your salary on a pre-tax basis. Each day of vacation will cost you one day's pay based on your regular salary as of a specific date, generally determined before the annual enrollment period each year. Regular salary for the purposes of buying vacation days is defined in the vacation plan summary, but in this case excludes shift pay. When you take a purchased vacation day, shift pay is included in your payment.

One day's pay equals your gross biweekly regular pay divided by 10 (for 10 working days in a biweekly pay period). The amount used to purchase the additional vacation days will be spread out over the year by deducting equal amounts from the first two pay periods of each month.

Making your vacation buying election

You can elect to purchase additional vacation days during the annual enrollment period. You cannot change your election during the plan year. If you are rehired, a newly hired employee or are newly eligible for benefits, you may purchase vacation within 31 days of your hire date or the date you became eligible.

Taking purchased vacation days/forfeitures

This benefit comes with its own set of rules (some of which are due to IRS regulations), including:

- Purchased vacation days can only be taken after you have used your regular vacation days. They can be taken before Kemper days.
- Purchased days can be taken in whole or half-day increments.
- You may be able to take an unscheduled purchased vacation day with the approval of your supervisor.
- Purchased vacation days must be taken in the year for which they are purchased. They cannot be carried over into the next plan year. This means the time off must be used during the specified plan year or paid out as described in the next paragraph.
- Before year-end, you may receive a payout for unused purchased vacation days.

Shortly before year-end, you will receive a letter from the Payroll department notifying you of the number of unused purchased vacation days you have remaining and asking whether you wish to receive a payout for any unused purchased vacation days. Your supervisor must initial and date the letter. You must return the letter to the Payroll department.

The refund will be taxable income.

Purchased vacation days that are not used or paid out by the end of the plan year will be forfeited.

If you are receiving salary continuation or workers compensation benefits at the end of the plan year and are unable to use your purchased vacation days in that plan year, you will receive a payout for the purchased days up to the number of days you are receiving salary continuation or workers compensation. In order to be reimbursed, your supervisor or manager must provide Payroll with a written request for the payout.

Recovering overpayments and contributions

The plan may recover unpaid contributions and any other amounts that may be owed or due the plan. These recoveries may be made directly from you, your salary or by deducting these amounts from benefits payable.

Interpretation of plans

The plan administrator has the authority and retains all discretion necessary to decide and/or construe all questions arising under the terms of the benefit plans and each of the benefit coverages therein (including all benefit-related programs and services). The plan administrator's retention of discretion thus applies to (but is not limited to) questions arising because of ambiguities, inconsistencies, or omissions, as well as questions as to the rights or eligibility of employees, dependents and beneficiaries, as applicable, including questions as to the payment or value of the benefits under the plans.

The discretionary determinations by the plan administrator with regard to interpretation of plan provisions as well as to all matters arising under the benefit plans are made in good faith and binding on all persons. A misstatement or other mistake of fact will be corrected when it becomes known, and the plan administrator will make such adjustment as it considers, in its discretion, equitable and practicable. Each benefit plan (and the benefit coverages therein) has its own procedures for submitting a claim and for appealing a decision on a claim. It is important that you refer to each plan's discussion of this topic for details.

The benefit review process

At any time during the benefit review process, you will have the opportunity to review all documents pertinent to the benefit decision.

First benefit review
If there are any instances where your benefit is in dispute, you have a right to make a written request for a review of your benefits within 60 days from the end of the plan year. Your formal written request for a review of benefits should be sent to: Plan Administrator, Kemper Insurance Companies, Corporate Human Resources, D-8, 1 Kemper Drive, Long Grove, IL 60049.

Your request will be reviewed and you will receive the results of that review within 60 days. If you do not receive a decision by that time, you should consider this a denial of benefits. However, you may be notified in writing of any special circumstances requiring an extended review period of up to 60 more days. If you do not receive a decision within this 60 days, you should consider this a denial of benefits.

Second benefit review
If you still believe you were improperly denied benefits after going through the steps above, you may submit a written request for a second review of your benefits.

You must make this request within 60 days from the date of the first review decision and explain why you are requesting a second review. You should address your second benefit review request to the plan administrator at the address given above.

The plan administrator will review your request with the benefit review committee and provide you with a written decision within 30 days. The plan administrator reserves the right to extend the time to provide you with a written decision. You will be notified in writing of the reasons for the delay and the date you may expect the final decision.

If you transfer between Kemper companies

For information on how your purchased vacation may be affected when you transfer from one Kemper company to another, refer to the Events affecting benefits section.

When participation ends

You can no longer participate in vacation buying if:
- the plan year ends;
- your employment terminates;
- you become a part-time employee;
- you are on a leave of absence for more than 10 days (unless you are receiving salary continuation or Kemper military leave pay);
- you retire or die;
- the company changes or terminates the plan for all participants or for certain classifications of participants.

If you can no longer participate for any of the above reasons, except for the plan year ending, and you have paid for but not taken all your purchased vacation days, your contributions will be refunded to you in your next or your last paycheck. The consequences of the plan year ending are described earlier in "Taking purchased vacation days/forfeitures".

Conversely, if you have taken purchased vacation but have not fully paid for them, the balance you owe will be deducted from your next or your last paycheck. You are responsible for paying any balance by check. In the event of your death, the balance owed the plan will be waived.

Administrative information

The following are discussed in detail in the Administrative information section:

- plan sponsor, address and identification number;
- plan administrator and address;
- agent for service of legal process;
- plan identification;
- plan funding;
- plan interpretation;
- the company's right to amend, modify or terminate the plan;
- your rights under ERISA

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Benefit Basics

Overview

The following section outlines the provisions that apply in general to all Kemper benefits, and programs. With regard to those benefits protected under ERISA, the information in this section, plus the information provided in each benefit's summary and the Electing Kemper Benefits, Events affecting benefits and Administrative information sections, provides you with the information required by ERISA.

Eligibility for all benefits

You're eligible for the benefits described if:

- you are on the U.S. payroll working for Lumbermens Mutual Casualty Company, including certain participating subsidiary and affiliate companies.
- you are a regular full-time or regular part-time employee scheduled to work 20 or more hours per week*;
- you meet the specific eligibility requirements outlined in each benefit's summary.

The above requirements also apply to your ability to participate

in other programs and services.

** If you worked less than 20 hours per week as of Dec. 31, 1991, and have continuously worked less than 20 hours per week since that time, you are eligible for all benefits, subject to each benefit's requirements,* ***except*** *vacation buying. You must be a regular full-time employee to be eligible to purchase vacation days.*

Eligibility for benefits

You

In addition to the eligibility provisions stated above, each benefit plan has its own specific eligibility requirements that can be found in each Summary Plan Description. You may find you're eligible to participate in one benefit plan and not another.

Your dependents

You may elect coverage for your eligible dependents under the medical, dental and voluntary accident plans.

Eligible dependents include your lawful spouse and your or your spouse's unmarried children up to age 21. Coverage for a child may be extended to age 25 if the child is a full-time student in a state-accredited educational institution. When that child graduates or stops attending class full-time, gets married, or becomes employed full time, coverage ends. (S)he may be able to continue coverage under the medical and dental plans for up to 18 months through COBRA continuation coverage.

"Children" refers to:

- your or your spouse's natural or adopted children or stepchildren who are financially dependent on you or your spouse;
- your natural or adopted children who live with you even if they are not financially dependent on you, provided they are financially dependent on another parent/guardian;
- other children who live with you and are financially dependent on you or your spouse.

"Financially dependent" means you, your spouse or another parent/guardian provide more than half the child's support as determined by federal income tax laws and regulations. An adopted child is eligible for coverage on the date of his or her placement with you. "Placement" means you are legally responsible for the care and total or partial support of the child.

If your dependent child loses eligibility and subsequently re-establishes eligibility, your child will be considered a new dependent. For example, you've elected medical coverage for

your 21-year-old son because he's in school. He drops out, losing eligibility as a dependent. He later re-enrolls, regaining eligibility. He will be considered a new dependent for eligibility purposes and you have 31 days from the date he begins school again to add him as a covered dependent.

You may elect coverage for a dependent child with a mental, physical or developmental disability as long as the disability began before the time the child turned age 21, or 25 if the disability began while the child was a full-time student. Coverage for a handicapped child may be continued upon reaching the maximum age of 21 or 25 as long as:

- the child is not capable of self-support due to the disability;
- the child remains financially dependent on you or your spouse;
- notice of the disability and financial responsibility is provided as requested by the plan administrator

Kemper couples
If both you and your spouse are Kemper employees and eligible for benefits, you are considered a "Kemper couple." The following benefit provisions apply to Kemper couples:

- You can be covered under a benefit as an employee or a dependent, but not both at the same time.
- One of you may be considered the dependent of the other when electing coverage under the medical, dental and voluntary accident plans. In this case, your eligible children may be covered as dependents of the spouse who is covered as the "employee." If both you and your spouse elect "employee only" coverage, only one of you can cover dependent children.
- If you are covered as a dependent on your spouse's Kemper coverage and your spouse terminates employment with Kemper or loses benefit eligibility, you may elect coverage as an employee and for any covered dependents. However, you must do so within 31 days to continue coverage.

You and your spouse may each elect separate Health Care Accounts. An account can be used to pay expenses of either person, but a specific expense can be reimbursed only once and not from both accounts. The same also applies to Dependent Care Accounts. See these benefit's summaries for more information.

If you decline coverage

If you elect "No coverage" for yourself or your eligible dependents you must wait until the next annual enrollment to elect benefits. If you have an eligible change in family status,

you may be able to elect coverage at that time. See Events affecting benefits for more on family status changes.

Coverage categories

You can choose from four different coverage categories when electing medical and dental coverages:

- Employee only
- Employee plus spouse
- Employee plus child(ren)
- Family

To find out which coverage categories are available under a given benefit plan, refer to that benefit's summary. Coverage categories can only be changed during the annual enrollment period or when you experience an eligible change in family status. Special rules apply in both cases and are explained in the Electing Kemper Benefits section.

Credited service

Many of the benefits offered at Kemper base your eligibility and benefit amount on your length of credited service with the company. Credited service is your total employment as a regular full-time employee or regular part-time employee scheduled to work 20 or more hours per week.

Your credited service date is always your original hire date unless you have a break in credited service, or the date you begin working full time or part time working 20 or more regularly scheduled hours per week. If you have been continuously working less than 20 hours per week since Dec. 31, 1991, you will continue to receive credit for your current service.

Credited service includes your employment with Lumbermens Mutual Casualty Company and certain participating subsidiary and affiliate companies. Credited service also includes certain employment periods with Kemper Corporation or its direct or indirect subsidiaries.

For complete details on how your credited service is determined, refer to the Retirement plan section, particularly if you're a re-hired employee or if you have a period of employment when you are regular part-time scheduled to work less than 20 hours per week, or a temporary employee.

Paying for benefits - contributions

Kemper pays the full cost of some of your benefits. You and the company share the cost of most benefits. Each year the

company determines the total costs of benefits and the portion of those costs it will pay. Your cost (the employee contribution) is the remaining portion, which is paid for through payroll deductions. While some benefits do not currently require employee contributions, the company, at its discretion, may require contributions at some point in the future.

Benefit contributions are taken from your regular pay. If you are receiving salary continuation payments or full or partial pay, contributions will be deducted from those payments. In all other cases, you will be required to pay contributions with a personal check. In addition, savings and profit sharing contributions are deducted from bonuses and referral awards. If your salary in a pay period is temporarily insufficient to cover all of your benefit contributions, Payroll will take missed deductions in subsequent checks.

Pre-tax contributions
You pay for most benefits with pre-tax contributions. This is a tax-effective way for you to pay for your benefits because, based on current law, you pay no federal income or FICA tax and, in most states, no state income tax on these contributions.

When you elect benefits paid for with pre-tax contributions, your enrollment through the Benefits Center serves as a salary reduction agreement. This means that in lieu of paying you the full amount of your salary, you are directing the company to reduce your pay by your cost of the benefits you elected.

Your contributions for benefits depend on the plan, options and coverage categories you elect.

Based on current tax law, significant pre-tax contributions may affect your future Social Security benefits and limit the total amount that can be contributed to your savings and profit sharing account.

After-tax contributions
Other benefits, including long-term disability coverage, are paid for with after-tax contributions.

Recovering overpayments

Each benefit or program maintains the right to collect directly from you, or from future benefit or program payments, any overpayments made to you or on your behalf.

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Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

For additional information contact:

Senate Ways and Means Committee
March 5, 2003 123-S

FY 2004 Federal Block Grants

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Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Ways and Means Committee, 123-S
March 5, 2003

FY 2004 Federal Block Grants

Mr. Chairman and members of the Committee, thank you for holding this federally required hearing and the opportunity to provide you information on the Federal Block Grant programs administered by the Department of Social and Rehabilitation Services.

Summary information on the following individual federal block grant programs is included in this document.

Federal Block Grant Program		FY 2004 GBR
Social Services Block Grant (SSBG)	$	23,134,390
Block Grant for the Prevention and Treatment of Substance Abuse		12,184,265
Community Mental Health Services Block Grant		3,436,330
Low Income Energy Assistance Block Grant (LIEAP)		12,452,454
Projects for Assistance in Transition from Homelessness Block Grant (PATH)		300,000
Total	**$**	**51,507,439**

The total amount of federal dollars appropriated for these block grant programs is $51.5 million in FY 2004, if not otherwise adjusted by Congress. Our total federal funding, in all programs, is over $1.3 billion. These block grants account for less than five percent of our federal funding.

SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant supports a variety of social service programs SRS administers. This is the twenty-first year of the social services block grant program.

For FY 2004, the GBR includes $23.1 million Social Services Block Grant funds. The estimated expenditures are as follows:

Services		FY 2004 GBR
Child Care Services	$	493,912
Developmental Disability Community Support Services		7,563,615
Independent Living Services		160,373
Mental Health Services		2,934,316
Adoption Services		7,379,614
Adult Protective Services		182,829
Field Operations - Child and Adult Protective Services		4,419,731
Total	**$**	**23,134,390**

Totals include the TANF transfer of $4.3 million.

Services are provided to individuals who are deemed eligible based on two criteria: 1) personal need; and 2) financial need. Personal need is based on one of the five national goals: 1) helping individuals to become economically self-supporting; 2) helping individuals to reduce dependency and become self-sufficient; 3) providing protective services for those in need (regardless of income); 4) providing services to help persons to remain in their own homes; and 5) when no other alternatives exist, providing services to help persons receive the most appropriate institutional care (i.e., adult care homes, state institutions, private institutions, etc.).

Financial need is based upon an individual's income. The state's established maximum income level for SSBG is 185 percent of the federally established poverty guideline. A single individual may not have a gross income exceeding $1,384 per month. This scale is graduated upward according to family size.

The social services block grant funds will continue to be used on a statewide basis to purchase services, to fund direct grants, and to provide direct services by SRS employees.

BLOCK GRANT FOR THE PREVENTION AND TREATMENT OF SUBSTANCE ABUSE

The Block Grant for the Prevention and Treatment of Substance Abuse is authorized by Public Law 102-321. The Governor's Budget Recommendation includes $12.2 million in Substance Abuse Block Grant funds. The funds will be utilized as indicated below:

Services		FY 2004 GBR
Administration	$	565,069
Substance Abuse Prevention and Treatment Services		11,619,196
TOTAL	**$**	**12,184,265**

In our prevention efforts, SRS utilizes a regional approach. Within each of the regions, or SRS Management Areas, high risk data concerning families, youth, and schools is used to target prevention services to communities with high risk factors for substance abuse.

Our treatment approach is to fund programs that provide the least restrictive environment for recovery from alcohol and other drug addictions. The use of five regional assessment centers to accurately assess the level of care needed for each client is allowing the client to receive the most appropriate and cost effective form of treatment available to the majority of Kansans. Priority populations served are pregnant women, women with children, anyone who has been exposed to or is at high risk for TB and/or HIV, and lastly, those who would not be able to afford treatment otherwise. While clinically sound treatment for all who seek those services is our goal, we also place great emphasis on treatment outcomes and improvement in the delivery system. Treatment services funded by the Block Grant for the Prevention and Treatment of Substance Abuse are projected to provide services for over 14,000 persons who seek treatment. In addition, our prevention centers are projected to reach over one million persons during FY 2003.

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

The Community Mental Health Service Block Grant is distributed via a performance based system of contracting to the 27 Community Mental Health Centers (CMHCs).

For FY 2004 SRS is budgeted to expend $3.4 million under this grant. Less than 5 percent of these funds is allocated to administration.

Services	FY 2004 GBR Amount
Administration	$ 165,353
Community Mental Health Services	3,270,977
TOTAL	**$ 3,436,330**

CMHCs funded under these contracts provide an organized and comprehensive community-based system of supports and services for individuals with severe and persistent mental illness and for children with serious emotional disturbances. CMHCs have a combined staff of over 2,000 and provide mental health services to every county in the state. These independent and locally-operated centers foster a quality system of services for the benefit of citizens needing mental health care and treatment.

A portion of the block grant funds are used by the CMHCs to provide services to the target population of adults with severe and persistent mental illness and children with serious emotional disturbances. Services are provided based on each individual's strengths and needs. Three universal programs funded by the block grant are (1) community support services, (2) community based services, and (3) 24-hour emergency services. The services for the target population also may include:

- case management
- residential programs
- vocational programs
- drop-in centers
- medication management
- partial hospitalization
- psychosocial rehabilitation programs
- mental health services to homeless
- consumer/self-help programs
- compeer
- attendant care

The focus of this federal block grant in recent years has turned toward enhancing the state service system for persons with mental health issues. To that end, the other portion of the block grant funds is dedicated to filling service gaps in the Kansas system which have been identified by the Governor's Mental Health Services Planning Council. SRS issues

Requests for Proposals (RFPs) to CMHCs to provide specialized services designed to fill the service gaps. Currently the federal block grant money is funding programs across the state focusing on:

- cultural diversity
- forensic services (in partnership with the substance abuse service system, the Department of Corrections and the Juvenile Justice Authority)
- consumer-run organizations
- children's 24-hour crisis mobile response
- services for youth transitioning to adulthood

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIEAP) BLOCK GRANT

The federally funded Low Income Home Energy Assistance Program (LIEAP) Block Grant helps households pay energy costs. The 2004 Kansas allocation is estimated to be $16.1 million. The FY 2004 Governor's Budget Recommendation for the LIEAP Program was made prior to Congress' federal FY 2003 LIHEAP appropriation. Under the recent appropriation, Kansas will receive an increase of $1,804,337 over the federal FY 2002 award, allowing $1,689,284 more for energy assistance benefits and an increase of $116,728 in transfers to the Weatherization Program in state FY 2004. Assuming stable funding, SRS proposes utilization in the following manner:

1. **Energy Assistance (85 percent of the grant)** - Utility or fuel assistance is provided to qualifying households whose income is under 130 percent of poverty. For a one-person household, the income limit is $973 monthly. At this level, households typically have difficulty paying for basic living costs such as housing, fuel, utilities, food, and medicine. Their vulnerability is worsened by medical conditions, disabilities and other problems. Most LIEAP recipients are older persons with "low-end" Social Security benefits, single parent families living on the minimum wage, or disabled individuals.

As a condition of eligibility, applicants must also demonstrate recent utility payments. This state-added requirement emphasizes the household's responsibility for paying its own fuel costs, promotes the importance of maintaining a regular payment history, and provides positive reinforcement. By supplementing the household's own payments, LIEAP helps elderly and disabled persons continue to stay in their homes, and protects vulnerable families who are at risk.

Applications are mailed to targeted groups of individuals who may need assistance. Completed applications may be mailed without need to visit the SRS Office. About 300 volunteer organizations help distribute outreach information to households who are unaware of the assistance. SRS verifies income by accessing data bases e.g., Social Security, workman's compensation and other systems.

Once the household is determined eligible, benefits are applied to the household's fuel or utility account to ensure that the benefit is used for energy purchases. Benefit levels vary according to household income and size, fuel type, dwelling type, and the household's utility rates. The recipient may split the benefit between two vendors (e.g., natural gas, electric, propane, or wood vendors).

About 31,800 households are expected to receive assistance in FY 2004 with a projected annual benefit averaging $366.

2. **Weatherization Assistance** (15 percent of the grant) - Federal regulations allow States to use up to 15 percent of the LIEAP grant for weatherization improvements. If funding permits, the Department proposes transferring the maximum allowed level (estimated at $2.1 million) to the Weatherization Program.

BLOCK GRANT FOR PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)

Kansas is a minimum allotment state under this federal formula grant program. Since 1993, $300,000 has been received each year.

All funds are distributed to homeless programs at five community mental health centers (CMHCs). The current allocations are as follows:

Program		FY 2004 GBR
Valeo Behavioral Health Care	$	80,000
ComCare		95,306
Wyandot Center for Community Behavioral Healthcare		70,094
Bert Nash Community Mental Health Center		26,600
Franklin County Community Mental Health Center		28,000
TOTAL	**$**	**300,000**

Valeo Behavioral Health Care (Shawnee County), Comcare (Sedgwick County), and Wyandot Center for Community Behavioral Healthcare: PATH block grant funds at these centers allow staff to provide outreach and case management services to persons who are homeless and mentally ill. Case managers help people secure transitional and permanent housing, health services, and mental health and substance abuse services in appropriate cases.

Franklin County CMHC and Bert Nash CMHC (Douglas County): Both of these centers provide outreach case management and work to link homeless persons with health, mental health and substance abuse services. Case management assists persons with transitional and permanent housing and vocational services.

Maintenance of effort, matching, and administration limit requirements of the federal block grants

Grant Name	Admin Limit	Maintenance of Effort and/or Match	FY 2004 GBR MOE and Match (State funds)
SSBG - Social Services Block Grant	None	Neither Required	$0
SAPTBG - Substance Abuse Prevention and Treatment Block Grant	5%	MOE required- avg of prior 2 years	$8,321,123
CMHBG - Community Mental Health Block Grant	5%	MOE required- avg of prior 2 years	$62,068,474
LIHEAP - Low Income Home Energy Assistance Program	10%	Neither Required	$0
PATH - Projects for Assistance in Transition for Homelessness Block Grant	4%	MOE required- avg of prior 2 years and 25% State match required	$100,000

K A N S A S

RODERICK L. BREMBY, SECRETARY

DEPARTMENT OF HEALTH AND ENVIRONMENT

KATHLEEN SEBELIUS, GOVERNOR

TESTIMONY ON

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

to

Senate Ways and Means Committee

Presented by: Michael Moser, MD, MPH

March 5, 2003

Chairperson Morris and members of the Senate Ways and Means Committee, I am pleased to appear before you today to discuss the Preventive Health and Health Services Block Grant and the Maternal and Child Health Services Block Grant.

In the early 1980's, the federal block grant programs were initiated. Funding from a number of programs was consolidated into block grants to provide centralized administrative oversight. The Kansas Department of Health and Environment participates in two federal block grant programs, the Preventive Health and Health Services Block Grant (PHB) and the Maternal and Child Health Services Block Grant (MCH). By federal regulation, public hearings are required for both Block grants. This hearing meets public review and comment requirements for these grant programs for public input into expenditure of block grant funds toward priority state health needs.

The Preventive Health and Health Services Block Grant

This block grant supports preventive health programs that address preventable factors that contribute to the leading causes of premature death and disability. Program objectives and activities must be consistent with the Year 2010 Health Objectives for the nation. A 1992 amendment to Title XIX, Part A, of the PHS Act significantly changed the Block Grant application process and reporting rules, limiting previous state flexibility in spending from this grant and requiring linkage of program activities to the National Health Objectives. Beginning with the fiscal year 1993 application, KDHE responded to the new requirements by:

1. Establishing a process to assess Kansas status relative to the Healthy People objectives and targets;

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2. Using these data to establish a state implementation plan to respond to critical preventive health needs and provide support for priority activities not adequately supported from categorical funding sources;
3. Providing a description of the programs and projects that are funded with the PHHS block grant and estimating the number of individuals to be served;
4. Establishing a state Preventive Health Advisory Committee, chaired by the state health officer, to make recommendations relative to the state plan, and holding public hearings on the state plan as stipulated by law;
5. Establishing an ongoing process for public review and comment; and
6. Measuring progress towards meeting preventive health objectives, including developing the necessary surveillance systems.

Current law stipulates that Preventive Health and Health Services block grant funds be used to supplement and increase the level of state, local and other non-federal funds; supplantation of non-federal funds is not allowed. State expenditures for the selected health activities are to be maintained at a level that is not less than the average level of the two years preceding the fiscal year for which federal funds to supplement that activity are requested.

Section 1904 of the governing law stipulates that Preventive Services block grant funds may be used for the following:

a. Activities consistent with making progress toward achieving the National Health Objectives for the health status of the population;
b. Preventive health service programs for the control of rodents and for community and school based fluoridation programs;
c. Feasibility studies and planning for emergency medical services systems and the establishment, expansion, and improvement of such systems;
d. Providing services to victims of sex offenses and for prevention of sex offenses; and
e. Program activities related to planning, administration and education, including evaluation of the Year 2010 Health Objectives addressed in the state plan.

A state may not use the Block Grant funds to :

a. Provide inpatient services;
b. Make cash payments to intended recipients of health services;
c. Purchase or improve land, purchase, construct, or permanently improve any building or other facility, or purchase major medical equipment;
d. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds; or,
e. Provide financial assistance to any entity other than a public or non-profit private entity.

The Maternal and Child Health (MCH) Services Block Grant

The Maternal and Child Health Services Block Grant is authorized under Title V of the Social Security Act. It is intended to support activities to promote and improve the health of all Kansas mothers and children. As the recipient agency for these funds, KDHE's role is to provide leadership and to work in partnership with communities, public-private partners, and families to strengthen the maternal and child health (MCH) infrastructure, assure the availability and use of "medical homes",

and build knowledge and human resources in order to assure continued improvement in the health, safety, and well-being of the maternal and child health population. The MCH population includes all Kansas women of reproductive age, infants, children, adolescents, and their families including fathers. Programs for children with special health care needs are specifically identified as part of the MCH block grant scope. Funds are allocated to Kansas through the national MCH block grant formula. In recent years, enhanced planning and reporting requirements have been implemented in order to improve accountability for these funds.

MCH block grant rules require that every five years each recipient State must conduct an assessment of State maternal and child health needs. There are detailed requirements concerning the conduct of the state needs assessment. Based on this detailed review of data from multiple sources, the State must specify between 7 and 10 priority needs. Kansas completed its five year needs assessment (www.kdhe.state.ks.us/jsna) in July, 2000. The priority Kansas maternal and child health (MCH) needs identified through this process, reviewed and revised in 2002 are:

1. Improve access to health care services for Kansas women and children.
2. Reduce health disparities in the MCH population
3. Improve data infrastructure, epidemiologic capacity and analyses for state and community problem solving.
4. Decrease family violence.
5. Improve nutritional status and physical activity to address obesity
6. Improve oral health status and access to oral health services
7. Increase access to mental health and substance abuse services for women and children.

Through 2005, allocation of resources from the Kansas MCH block grant must reflect these priorities. To facilitate a better response, KDHE has reduced categorical barriers to use of available resources through consolidation of a number of funding streams into local MCH block grants to local agencies. Local agencies utilize state needs assessment data and other data to prioritize their own needs. Funds may be spent for local priority maternal and child health needs. Reporting is structured to retain accountability while providing flexibility for communities.

Description of Services Funded in SFY 2003

A. Aid to Local Agencies

MCH and PH B - *Maternal and Child Health Grants* - All 105 Kansas counties provide maternal and child health services to optimize the health of Kansas families, in particular for uninsured families and those with limited access to care. Counties must provide comprehensive services by coordinating with all available community resources. Based on a community health assessment, counties provide services, including prenatal care coordination, home visits, child health services, and others. Up to 30 percent of the funding can be used flexibly to address state and locally identified MCH priorities through appropriate interventions.

PHB - *Chronic Disease Risk Reduction Grants*- These grants are awarded to support development and implementation of community-based programs to decrease premature death and disability due to cancer and cardiovascular disease, the two leading causes of death in Kansas. Program interventions are designed to decrease the leading modifiable risk factors for cancer and cardiovascular disease, including tobacco use, physical inactivity, and nutrition. Currently, 75

counties, representing almost 83 percent of the state's population participate in the program. Interventions are delivered through schools, work sites, churches, community organizations and other community settings.

MCH - *School Health Services Grants* - These funds partially support four local projects that provide health services including preventive and primary care in the school setting. These funds are awarded on a competitive basis after review of responses to a formal Request for Proposals.

MCH - *Teen Pregnancy Prevention* - These funds provide partial support for four (4) Teen Pregnancy Prevention Projects utilizing the South Carolina model of school and community education.

MCH - *Disparities Project*s - Funds are used for two projects (Sedgwick and Ford Counties) with the goal of reducing disparities in health status for racial and ethnic groups through community-based interventions.

PHB - *Special Health Promotion Grants* - Health Promotion projects fund specific services based on identified need. Funds will be awarded to Pittsburg State University for facilitation of a statewide initiative to promote physical activity and to the Center for Health and Wellness for the Black Churches Hypertension/Cholesterol reduction project in Sedgwick County.

MCH - *School Health Assessments* - Full or partial reimbursement to local health departments and community health centers for school entry assessments.

MCH - *Immunization* - Supplements local health department funding for immunization initiatives.

B. Transfers of Funding to Other State Agencies

PHB - *Rape and Sexual Offenses Prevention Education* - A specified amount of PHB funding awarded to Kansas is designated, per federal mandate, for sexual offenses programming. To avoid duplication and inefficiency KDHE transfers the funds to the Governor's Office to be used for local programs.

C. State Operations

MCH - *Center for Health and Environmental Statistics* - Data support to the MCH programs per memorandum of agreement.

MCH and PHB - *Division of Health* - Offsets costs for program and fiscal support to MCH and PHB programs.

MCH and PHB - *Local Health Department Support Services* - Support services for local health departments including but not limited to consultation, education and technical assistance provided by community nurse/public health specialists for maternal and child health and risk reduction/health promotion activities.

PHB - *Immunization Program* - Portion of operating expenses for the Bureau of Epidemiology and Disease Prevention.

MCH - *Child Care Regulation* - support for a portion of operating expenses for the Child Care Facilities Licensure and Registration program.

MCH - *Children with Special Health Care Needs* - Salaries and operating expenses to assure care coordination and reimbursement to health care providers for medical specialty services

MCH - *Nutrition* - Nutrition consultation to MCH programs.

MCH - *Newborn Screening* - Case management for newborns with positive screens

MCH - *Compliance Monitoring* - Portion of salaries and operating expenses to provide clinical and administrative oversight of local agency contractual compliance in providing maternal and child health services.

PHB - *Chronic Disease and Injury Prevention/ Health Promotion* - Portion of salaries and operating expenses for Bureau of Health Promotion (BHP). BHP staff play a key role in assessing the current chronic disease burden and in facilitating consensus development of statewide goals and strategies to alleviate that burden in Kansas. Staff facilitated a series of workgroup meetings involving more than 40 partners to develop a Comprehensive Cancer Control Plan and to identify strategies for implementation of consensus recommendations. Staff facilitate activities of the SAFEKIDS Coalition, a private/public partnership that provides leadership for decreasing unintentional injuries (number one cause of death) in the 0-14 age group. Activities include facilitating the BUCKLE UP program and the Mobile Child Safety Seat Check Up Van which provide safety seats to low income families and provide checks of installation of seats (finding a misuse rate of 86%), and the CYCLE SMART program which has provided low-cost bicycle helmets to more than 45,000 Kansans. Similarly, the Block Grant represents the only source of funds dedicated to prevention of cardiovascular disease, the number one over all cause of death among Kansans. Activities include promotion of proper nutrition and increased physical activity.

Thank you for the opportunity to appear before the House Appropriations Committee. With the assistance of my staff, I will be happy to respond to any questions you may have on these matters.