Approved: March 23, 2004
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairperson Patricia Barbieri-Lightner at 3:30 p.m. on February 19, 2004 in Room 527-S of the Capitol.

All members were present:

Committee staff present:
Bill Wolff Legislative Research Department
Ken Wilke, Revisor of Statutes
Renae Hansen, Secretary

Conferees appearing before the committee:
John Campbell, Kansas Insurance Department
Bill Sneed, State Farm
Larrie Ann Lower, Kansas Association of Health
Cheryl Dillard, Coventry
Brad Smoot, Blue Cross Blue Sheild of Kansas
Kathy Ostrowski, Kansans for Life
Beatrice Swoopes, Kansas Catholic Converence
Julie Burkhart, Pro Can Do
Jennifer McAdam, Planned Parenthood
Anna Holcombe, Kansas NOW
Scott Bruner, State Medicare

Others attending:
Twenty Six including but not limited to the attached list.

Hearing on:
HB 2689: Health insurance; required disclosures to policyholders for group health insurance.

Opponents:

John W. Campbell, General Counsel for the Kansas Insurance Department, (Attachment #1), presented testimony that states that the Kansas Insurance Department believes **HB 2689** is unconstitutional. They believe the premise of this that patient information belongs to the patient, period. There are those who can access it, and the HIPAA law is very complicated and specific on those individuals who can access the information. They believe that if the law were enacted it would be unenforceable as it has been preempted by HIPAA. Commissioner Sandy Praeger asked him to express to the committee she realizes there is a problem. The same individuals who appeared as proponents have been to their office and they have looked at this in detail and have looked for solutions. They are going to take this to the NAIC (National Association of Insurance Commissioners) to see if a consensus of some sort can be reached and then have this proposal taken to the people in Washington, DC. HIPAA puts up an extraordinary amount of protection and they believe this bill would not work with the federal legislation.

Questions were posed by: Representatives Bob Grant, Patricia Barbieri-Lightner, and Mario Goico.

William Sneed, Legislative Council for The State Farm Insurance Companies, (Attachment #2), specifically addressed on page 2 of the bill, section 3. They are uncertain as to why the section that requires property and casualty insurers to provide the policy holder with loss information has been included in the bill. They are asking that section 3 be stricken from the bill. Currently they are monitoring the bill and at this time have not taken a position on the bill.

Laurie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP), (Attachment #3), noted the disclosure requirements of the bill are included in section 2(b). The section says for a claim over $10,000 health plans would be required to release to policyholders(employers); the identity of the

patient, the diagnosis of the patient, the current health status of the patient and the identity of the health care provider providing the medical care or treatment. Under close scrutiny of the bill it may be interpreted as acceptable under HIPAA, but the requirements go further than would seem acceptable. They suggested that language be added that would indemnify health plans from paying any penalties if HIPAA regulations were found to be violated.

Questions were posed by: Representative Patricia Barbieri-Lightner and Revisor Ken Wilke.

Cheryl Dillard, Director, Governement Relations, Coventry Health Care, (Attachment #4), responded to items heard previously from proponents of the bill. No information that was requested in this bill is not already provided to companies employing over 200 people by Coventry Health Care. Less than 200 they are concerned that the information would be able to be identified to specific individuals. It is presented as aggregated data about inpatient care, outpatient care, top 25 prescriptions, top 25 class of drugs, the top 10 diagnosis, the top 10 provider locations, the number of visits to a chiropractor, the number of people in a group that are using the chiropractor, the number of people that are receiving mental health services, number of newborns, etc.... This is all aggregated data with no patient identification given. They very much hope the legislature does not support the release of names, as they believe this is not a good policy.

Questions were posed by: Representative Nile Dillmore.

Brad Smoot, Legislative Counsel, Blue Cross and Blue Shield of Kansas and Kansas City, (Attachment #5 and #6), noted **HB 2689** provides too much specific detail for broad dissemination. It is important to not release detail of names. Several examples of reports they do provide are attached. Included in his testimony is an example of a data company that collects and compiles for companies, data about their specific insurance usage. Some of the specific data this company collects, Blue Cross believes is proprietary information that should remain within the confines of the individual insurance company. It is data that includes what they have negotiated to pay the doctors, hospitals, and other health entities. In affect, the precise information that makes them competitive in the market place. BCBS believes this information to be crucial to maintaining their ability to compete in the insurance industry, and should not be released.

Questions were posed by: Representatives Nancy Kirk and David Huff.

The hearing was closed on **HB 2689.**

Hearing on:

HB 2761: Children covered by a plan for insurance coverage for children.

Dr. Bill Wolff gave a brief explanation on why this bill was introduced. This bill attempts to fill a gap for prenatal care for a mother who might otherwise be ineligible for it under the current Healthwave/ Medicare plans. In 2002 the Federal Government Health organization authorized states to provide healthcare to children from conception to 19 years of age instead of from birth. This would enable a family to claim one more dependent and thereby lower the amount of annual income it takes for a family to be in the poverty range and therefore enable them to attain care under the S-CHIP plan.

Proponents:

Kathy Ostrowski, Legislative Director of Kansans for Life, (Attachment #7), presented testimony in support of **HB 2761**, allowing funding through SCHIP for children in the womb. They support this legislation for two reason: 1. Healthy birth outcomes enhanced through pre-natal care benefit both individuals and society 2. Pregnant women who are ineligible for government assistance and feel financially driven to abortion, dramatically increases the risk of premature(including low and very low birth weight) babies in subsequent pregnancies.

MINUTES OF THE HOUSE INSURANCE COMMITTEE at 3:30 p.m. on February 19, 2004 in Room 527-S of the Capitol.

Questions were posed by: Representatives Ray Cox, Patricia Barbieri-Lightner, and Nancy Kirk.

The fiscal note for **HB 2761** was presented.

Scott Bruner, Social and Rehabilitation Services, (Attachment #8), presented some written testimony addressing this issue. His testimony shows currently what is covered and what acceptance of this bill would allow women to receive in the way of health care. He also helped answer a questions that were asked.

Questions were posed by: Representatives David Huff, Nile Dillmore, Mario Goico, and Nancy Kirk.

Beatrice Swoopes, Kansas Catholic Conference, (Attachment #9 & #10), spoke in favor of **HB 2761.** This bill helps women who might otherwise fall above the income dollar amount for healthwave care to receive help for prenatal care through SCHIP (State Children's Health Insurance Program), by increasing the number of people in a family through acceptance of a child upon conception as a member of the family and thereby lowering the income eligibility dollar amount. This would allow the pregnant woman to receive prenatal care that she might otherwise not be eligible to acquire.

Questions were posed by: Representatives Nancy Kirk and Scott Schwab.

Specific questions were directed to Scott Brunner about eligibility of State employees for this program by Representative Patricia Barbieri-Lightner. Dr. Wolff also contributed to this series of questions.

Opponents:

Julie Burkhart, Executive Director of Pro Kan Do, (Attachment #11), **HB 2761** could do more harm than good by pitting a woman's needs against the needs of the fetus. Social service programs are severely underfunded to begin with and this would take away funding needed for other areas. If the goal of this bill is to maintain the highest health standards for a woman's pregnancy, then why not propose expanding Medicaid. Additionally, the long term goal of this bill is to establish a fetus as a person under Kansas law, and making abortion illegal by directly challenging the *Roe v. Wade* language.

Questions and comments were posed by: Representatives Mario Goico, Mike Burgess, Mary Kauffman, Stephanie Sharp, Patricia Barbieri-Lightner, and Nancy Kirk.

Jennifer McAdam, Planned Parenthood of Kansas and Mid-Missouri, (Attachment #12), supports coverage for pregnant women. **HB 2761** is not true prenatal care as it does not address the health of the woman. The only change to current statute is to cover an "unborn child" from conception onward. In this bill the woman would loose her healthcare when the child was born and thereby compromises women's overall health. This bill does not address the woman's health but only that of the unborn child. Recommended alternatives to enacting this legislation included an expansion of Medicaid coverage to 185% of the federal poverty line through a state plan amendment, or to 200% through a waiver from the Center for Medicare and Medicaid Services within the U.S. Department of Health and Human Services. Attached to her testimony is a statement from the March of Dimes.

Anna Holcombe, Kansas National Organization for Women, (Attachment #13), opposes **HB2761** because although this legislation would give prenatal care to woman who do not qualify for Medicaid, solving the problem of women's lack of prenatal care should not include ideological definitions of when life begins. This bill does not address the underlying issue of poor health care options for women who fall just above the poverty levels established and cannot receive health care dollars to improve their overall long term health. While it does provide them some care during pregnancy and 3 months post partum, it does not really address the long term health insurance needs of a woman. An alternative proposal that would truly address the problem of low income women's lack of access to prenatal care would be strongly supported by Kansas NOW.

Questions were asked by: Representatives Patricia Barbieri-Lightner, Mario Goico, Mike Burgess, and

MINUTES OF THE HOUSE INSURANCE COMMITTEE at 3:30 p.m. on February 19, 2004 in Room 527-S of the Capitol.

Mary Kauffman.

Hearing closed on **HB 2761.**

Discussion open on:

HB 2563: Motor vehicles; increase amount for reporting accidents to $1,000.

Representative Mario Goico moved to amend **HB 2563** to insert the words electronic instead of consolidated magnetic tape and make it in force January 1, 2005,, seconded by Representative Mike Burgess, motion passed unanimously

This takes into consideration the recommendation of the Department of Transportation to use electronic transmission and to change the affective date to January 1, 2005.

Representative Nile Dillmore moved to amend **HB 2563** from the $1,000 reporting amount to $1,500, seconded by Representative Jan Scoggins-Waite.

Comments were made by Representatives Bob Grant, Nile Dillmore, Mario Goico, Mary Kauffman, and Eber Phelps.

The question was called.

The motion passed unanimously.

It was discussed that perhaps to be amended on the floor of the house would be the dollar amount applying towards each vehicle and not the total dollar amount per accident.

Representative Cindy Neighbor moved the passage of **HB 2563** as amended to the floor of the house, seconded by Representative Mario Goico, motion passed unanimously.

Representative Mario Goico would carry the bill to the floor of the House.

Meeting Adjourned.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: February 19, 2004

NAME	REPRESENTING
Sarah Novascone	Federico Consulting
Bill Sneed	State Farm
Anna Holcombe	Kansas Now lobbyist
Jennifer McAdam	Planned Parenthood
Sue Ann Schultz	IMA
Scott Brunner	SRS
[illegible]	BCBS
Beatrice Sawyer	Kansas Catholic Conference
[illegible]	PEC
Natalie Haag	Security Benefit
Brad Smoot	BCBS
LARRY MAGILL	KS. ASSN OF INS AGENTS
Tim Gregory	KS Chamber
Judy Smith	CWA of KS
Joy E. Bourdess	CWA of KS
BILL YANEK	KS Assn of REALTORS

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

HOUSE COMMITTEE
ON
INSURANCE

Testimony of John W. Campbell
General Counsel for the Kansas Insurance Department
In Opposition to House Bill 2689
February 17, 2004

Madam Chair and Members of the Committee:

My name is John Campbell. I am the General Counsel for the Kansas Insurance Department. I am here today to testify in opposition to House Bill 2689.

Last April, the privacy provisions of the federal law known as the Health Insurance Portability and Accountability Act (HIPAA) went into effect. Since that time, health care providers and insurance providers have been attempting to find the best way to comply with HIPAA. HB 2689 is one of these attempts and, in the opinion of the Kansas Insurance Department, it is a futile attempt.

As you know, HIPAA and its various regulations are federal law. State laws which attempt to add to federal law are suspect. HIPAA permits the disclosure of summary information to the employers if they request it for the purpose of obtaining premium bids or modifying, amending, or terminating the group health plan. There are even means where Protected Health Information (PHI) can be made available under certain restricted circumstances.

As a rule, HIPAA privacy regulations preempt state laws that are not at least as stringent as HIPAA. HB 2689 requires disclosure of PHI. Requiring disclosure by state law where the HIPAA privacy rules merely permitted disclosure would provide less privacy protection than the federal rule and, in the Department's opinion, would be unenforceable.

My testimony today is not so much an endorsement of HIPAA, as it is an acknowledgment of reality. HIPAA is a federal law. Any person or business that acts under HB 2689, does so at its own peril. If HB 2689 is enacted the Department will of course follow the will of the Legislature and enforce state law, but we recommend that

the bill not be enacted and if it is, that any person or business seek guidance from the federal courts or bureaucracy before acting in reliance of HB 2689.

Thank you and I would be happy to answer any questions.

Polsinelli | Shalton | Welte

A Professional Corporation

Memorandum

TO: THE HONORABLE PATRICIA BARBIERI-LIGHTNER, CHAIR
HOUSE INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
THE STATE FARM INSURANCE COMPANIES

RE: H.B. 2689

DATE: FEBRUARY 17, 2004

Madam Chair, Members of the Committee: My name is Bill Sneed and I represent the State Farm Insurance Companies ("State Farm"). State Farm is the largest insurer of automobiles in the United States and Kansas. We appreciate the opportunity to testify on H.B. 2689. H.B. 2689 attempts to deal with health insurance disclosures. However, in Section 3 it requires property and casualty insurers to provide the policyholder with loss information upon the policyholder's request up to five years, or for the amount of time insured by the insurer, if less.

We are uncertain as to why this has been included in a health insurance bill. Secondly, we are completely at a loss as to what is meant by "loss information" as indicated in the proposal.

Next, assuming that we had some understanding of what "loss information" means, we are not certain as to what purpose there would be in providing this information to a policyholder, other than to furnish what has already been provided.

Thus, we must respectfully that the Committee act unfavorably on H.B. 2689, as we can find no basis in public policy that this section is needed in state law. I appreciate the opportunity to appear before the Committee, and if you have any questions I will be happy to answer them.

Respectfully submitted,

William W. Sneed

WWS:kjb

House Insurance
Date: 2/19/04
Attachment # 2

One AmVestors Place
555 Kansas Avenue, Suite 301
Topeka, KS 66603
Telephone: (785) 233-1446
Fax: (785) 233-1939

Kansas Association of Health Plans

1206 SW 10th Street
Topeka, KS 66604

785-233-2747
Fax 785-233-3518
kahp@kansasstatehouse.com

Testimony before the
House Insurance Committee
HB 2689
February 17th, 2004

Madam Chairman and members of the Committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, 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 other entities that are connected to managed care. KAHP members serve most all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid managed care and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on HB 2689. TPAs

The KAHP appears today in opposition to HB 2689 for many reasons, some of which I will discuss. Cheryl Dillard, Director of Government Affairs for Coventry HealthCare and Brad Smoot representing BCBS-KS and BCBS-KC will discuss others. Also present today to help answer questions if needed is Bill Tracy, President and CEO of United HealthCare of the MidWest and current President of the KAHP. Various other members of the KAHP are present also.

This bill causes concern to all KAHP members. On behalf of all members of KAHP, the Association is satisfied with the level of data available in the marketplace to prepare responses to requests for competitive health insurance proposals. The members are extremely uncomfortable with the disclosure requirements outlined in this bill as they pertain to personal health information.

The disclosure requirements are included in Section 2(b) items (1), (2), (3) and (4). This section says for a claim over $10,000, health plans would be required to release to policyholders (employers): the identity of the patient, the diagnosis of the patient, the current health status of the patient and the identity of the health care provider providing the medical care or treatment.

Under close scrutiny the bill's requirements may be able to be interpreted as acceptable under HIPAA, however the requirements go further than would seem acceptable. The proponents claim the release of the information sought through this legislation will not violate HIPAA because the policyholders will certify that they have satisfied the conditions that must be met in order to receive the exact type of health information protected by HIPAA. Because health plans are a covered entity under HIPAA privacy and subject to the penalties of unauthorized disclosures of personal health information, we are concerned about this certification process.

House Insurance
Date: 2/19/04
Attachment # 3

We would suggest language be added that would require the policyholder to indemnify health plans for any amounts we are required to pay in penalties or settlements if a health plan is subsequently alleged to have violated HIPAA by disclosing personal health information pursuant to a faulty certification. We would also suggest a change to the legislation that requires the policyholder to not only certify compliance, but also will continue to fulfill all obligations that are required for that certification. You may want to consider having someone with some level of authority provide the certification, perhaps the Kansas Insurance Department.

Thank you and I'll be happy to answer any questions you may have.

COVENTRY
Health Care of Kansas, Inc.

TESTIMONY BEFORE THE KANSAS HOUSE COMMITTEE ON INSURANCE
TUESDAY, FEBRUARY 17, 2004
HOUSE BILL 2689
CHERYL DILLARD
DIRECTOR, GOVERNMENT RELATIONS
COVENTRY HEALTH CARE

Madame Chair and Committee Members, thank you for the opportunity to appear before you today in opposition to HB 2689. I'm Cheryl Dillard with Coventry Health Care, a managed care plan that serves the majority of counties in Kansas and is one of the health plans that serves Kansas state employees.

As I prepared my testimony, I discussed this legislation with my colleagues at Coventry and their reaction captures the depth of our concern, should this bill be enacted. Our chief actuary was emphatic in his statement that no claims data for any employer group smaller than 100 employees is statistically valid and that the data that would result from this bill would be "actuarial garbage". The young woman who prepares our current group employer reports told me how much time and effort she and her associates spent on formatting these reports so that they would, in no way, reveal identifying information to the employers about our members and their illnesses. Coventry currently provides group-specific reports to employers larger than 100 that contain the diagnosis and the cost of each illness or episode—no employee names and no prognosis or health status. Only the names of the top ten hospitals and physicians used most frequently by the employees are aggregated and released to lessen the chance that an individual patient-physician relationship could be identified. Our medical directors wondered whether every treating physician in the network would be concerned to know that HB 2689 could violate the long-protected physician-patient relationship, by revealing to employers and insurance agents the name of an individual patient and specific nature of that relationship. And finally, I queried our Marketing staff, "Had any employers been asking for this level of specificity?" The answer was "No." I asked what employers would do with this information if HB 2689 were enacted. Would they change the benefit plan, the co-payments, the deductibles, if they knew their store manager had cancer or their billing clerk needed kidney dialysis? The Marketing staff told me such changes would be unlikely and that such changes are prompted by the total group's risk profile, not the risk of an individual employee.

The question before you today is who does benefit if HB 2689 is enacted? It is not our members or our contracted providers whose privacy would be violated. It is definitely not the health plans that operate in a market that is already very competitive. This bill is not necessary and we urge you to oppose it. Thank you.

House Insurance
Date: 2/19/04
Attachment # 4

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816-941-3030 • Toll Free: 1-866-795-3995 • Web Address: www.chckansas.com

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Statement of Brad Smoot
Legislative Counsel
Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Kansas City
House Insurance Committee
Regarding 2004 HB 2689

February 17, 2004

Madam Chair and Members,

On behalf of Blue Cross Blue Shield of Kansas, a domestic mutual insurance company serving over 600,000 Kansans in 103 counties and Blue Cross Blue Shield of Kansas City, a hospital and medical service corporation serving 300,000 Kansans in Johnson and Wyandotte Counties, we are pleased to have an opportunity to comment on House Bill 2689.

For general public policy reasons and some technical legal reasons, we must respectfully oppose the disclosure of personal health information that would be required by H 2689. While there may be some question whether HIPAA prohibits the disclosure of the information required by this bill, there is a separate and more immediate question: Whether the state of Kansas ought to mandate that insurers provide the name, diagnosis, current health status and name of provider to employers for transmitting to agents, brokers and other carriers. See Section 2.

We provide much of the information required by this bill and fully understand why employers, agents and competing carriers need the data we provide. Attached to my testimony is a summary of what BCBSKS gives its larger employer groups. Most are provided free of charge; some for a nominal fee. While we provide most of these reports as a routine, some employers ask for special reports. We have always thought that those that request special reports ought to pay for them.

We, too, use such information in making our underwriting (pricing) decisions. However, Kansas' two BCBS plans don't need to know the name, diagnosis, current health status or physician in order to make our underwriting decisions or to compete for group insurance business. We win some new clients and lose existing clients on a regular basis in a very competitive environment. The suggestion that this bill is needed for there to be competition in the marketplace can be readily dismissed. Proponents of the measure took this "marketplace" argument to the Kansas Insurance Department which declined to force disclosure of personally identifiable health information as a means of correcting some alleged marketplace malfunction.

Sadly, the real impact of this legislation may be just the opposite of what is suggested by the proponents. Disclosure of such personal information may allow some groups to be

House Insurance
Date: 2/19/04
Attachment # 5

"cherry-picked" for better rates while those with less healthy risks will be unable to find anyone interested in insuring them. A group with cancer patients who have been cured may have lots of suitors. A group with cancer patients awaiting bone marrow transplants won't have a lot of bidders. The result: "cherry-picking" for the healthy groups and "carrier lock" for the sick groups.

The bill attempts to make itself HIPAA compliant by inclusion of Section 6, which says that nothing in the bill shall require carriers to violate HIPAA. Unfortunately, this may not be enough protection. HIPAA carries an over-arching limitation regarding the provision of personal information, that the "minimum necessary" information should be released. To the extent that most insurers in the state have historically been able to bid using less information, it is difficult to conclude that this additional information is in fact consistent with the "minimum necessary" rule. There are also other federal and state privacy laws, both statutory and judicial that need to be considered. What about the Federal Confidentiality of Alcohol and Drug Abuse Patient Records Act, 42 U.S.C. § 290dd-2 and its implementing regulations? Section 6 contains no exemption from the bill's mandated disclosure for this information. Do carriers have potential liability exposure if this personal health information is wrongfully disseminated? We think they do.

We know of no state that requires the dissemination of such personal data. Some states do have laws which deal with this general subject matter but do not go so far. See Virginia. We also know that several attempts in other states to require disclosure of personal health data have been rejected by lawmakers. See Utah. While it might be good to be first in the one hundred yard dash, it may not be so good to be the first state in the union to mandate disclosure of an identifiable patient's diagnosis and prognosis.

Finally, if the committee intends to work the bill, we would suggest several amendments. Any legislation should authorize a nominal fee for any data request and removed the mandated disclosure of the patient's name, diagnosis, provider and current health status. We would also suggest a grant of immunity to carriers who comply with the act or permit carriers to insist on indemnification agreements prior to delivery of personal health data. We also recommend that the name of the act be stricken or amended. This proposal has little or nothing to do with an employer's accountability or insurance affordability. It seems to us to be more related to business opportunities for agents and brokers and the unnecessary invasion of patient privacy. Thank you.

Reports

Standard Reports

Merit rated groups over 100 in size automatically receive a utilization analysis report and patient expense summary. These reports are provided at no cost to the group and are provided in conjunction with the group's renewal.

- Patient Expense Summary Report — This is a report that summarizes a group's total claims.
- RetroACCUrate Report (50+ enrolled contracts) — This is an annual year-end report that tells: a) when claims expense exceeds premium income, b) the amount that will be contributed to group reserves when premium income exceeds the cost of claims expense and retention, or c) what amounts will be carried forward for the next annual review when the group has amounts in excess of projected premiums.

Specialty Reports

The following reports are available upon request. Charges for these special reports are $100 per benefit period requested.

- Standard Utilization Analysis Report and an In-depth Analysis — Reports are available to groups of more than 100 in size.
- High Cost Listing — This report provides an illustration of high cost expenses incurred with a breakdown of services, number of occurrences, charges/paid data for year-to-date expenses.
- Financial Summary — This report provides month-to-date and year-to-date claims expense information for institutional (inpatient and outpatient), professional, dental, and prescription drug services. There will, however, be no MER report included in the summary.
- Enrollment Contract Counts — This is simply a group's enrollment by month or totaled for a certain period of time.
- Deductible/Coinsurance — This report provides claims expense accumulated toward the deductible or coinsurance amount with a breakdown by patient name.
- Insured Listing — This report provides insured and dependent information (i.e., first and last name, date of birth, sex, benefit effective date, IRC and type of contract). PCP information is also available upon request.

Customized Reports

These are available upon request and are tailored to respond to the group's needs.

Medical Claim Data Requirements

for Decision Master ™

Following is a set of guidelines and data element requirements necessary for analyses performed by Zywave, Inc. Please submit data and supporting documentation to:

Zywave

Attn.: Sarah Stier
2323 N. Mayfair Rd, Suite 600
Milwaukee, WI 53226
e-mail: sarah.stier@zywave.com

General Requirements

1) Please provide claim data for all medical claims processed during the reporting period specified.
2) Please provide the data elements listed below for each medical claim reported.
3) Please include a variable which differentiates employees from dependents (i.e., claimant relationship code).
4) Please include a variable which differentiates active employees from Medicare-eligible group retirees (if applicable).
5) Please provide this data via 3 1/2" diskette in a fixed-field, ASCII format. Please include a record layout which indicates field length and field format.
6) Please provide employee coverage counts (single/dependent/family) and fixed expenses (i.e. fees for administration, U.M., PPO, Stop Loss, etc.) for the reporting period specified.

Specific Data Element Requirements

a) Unique Scrambled Identification Number
b) Employee Status - see (4) above
c) Claimant Relationship Code - see (3) above *
d) Claimant Sex
e) Claimant Age
f) Place of Service *
g) Type of Service *
h) ICD-9 Diagnosis Code
i) CPT Procedure Code
j) Benefit/Service Code *
k) Provider Identification Number (federal tax ID if available) (May be scrambled) ***
l) Provider Name
m) Provider Type *
n) PPO Provider Indicator
o) Date(s) of Service (both from and through dates)
p) Paid Date (date processed)
q) Total Charged Amount
r) Total Paid Amount

* Please provide a list of valid codes and definitions
*** Each provider must have a unique scrambled ID number

1/24/2003 2:24:15 PM

House Insurance
Date: 2/19/04
Attachment # 6

Layout of Sample File Data *

Field	Start	Width**
Patient ID ***	1	16
Group	17	4
Relation(ship)****	21	4
Sex	25	2
Claimant Age	27	9
Place of Service (POS)****	36	7
Type of Service (TOS)****	38	4
Diagnostic Code (IDC-9)	42	6
CPT Code (CPT4)	48	6
Benefit/Service Code****	54	3
Provider Tax ID	57	10
Provider Name	67	35
Provider Type****	102	4
PPO Flag	106	2
From Date	108	9
Through Date	117	9
Process Date (Paid Date)	126	9
Total Charges	135	20
Total Paid Amount	175	20

Include the following information if available:

Ineligible Amount ($)

Ineligible Reason Code****

* This is the layout for the sample fixed length file enclosed.

** The width of your fields may vary from the sample.

*** For confidentiality purposes, we strongly encourage you to provide a scrambled employee ID number. However, each employee must have a unique ID number and that number must identify any claims related to that employee.

**** Please provide a list of valid codes and definitions.

Fixed Length Fields - ASCII Text File Layout - (Actual Data Received From A Carrier)

This Is Very Clean And Able To Be Mapped). [Only 19 Records Shown]. [Hard Copy File Layout Also Required].

*										*	*							
S		R				T	D			P	P	P	P	F	T	P	T	T
C		E				Y	I	C	B	R	R	R	P	R	H	R	O	O
R	G	L				P	A	P	E	O	D	Q	O	O	R	O	T.	T.
A	R	A				E	G	Y	N	V	V	V		M	U	C		
H	O	Y	S	A	P								F			E	C	P
B	U	I	E	G	O	S	C	C	C	TAX	N	T	L	D	D	S	H	A
L	P	O	K	E	S	E	O	O	O		A	Y	A	A	A	S	A	I
E		N				R	D	D	D	I	M	P	G	T	T		R	D
D						V	E	E	E	D	E	E		E	E	DATE	G	
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4.27E+08	1	EMM	M	40	J	5	V722	7110	95	4.00E+08	BERGER,	DDS	D	95-05-08	95-05-08	95-08-10	350.00	-
3.67E+08	10	SPF	F	22	G	10	V681		94				D	96-03-12	96-03-12	96-03-29	132.09	39.85
3.72E+08	11	SPF	F	13	G	10	4655		94				D	95-06-26	95-06-26	95-03-05	-	-1.47
4.00E+08	101	EMM	M	32	O	5	V722	7230	38	4.00E+08	ELMBROO	SURGECL	1	95-01-16	95-01-16	95-05-12	-	-
4.04E+08	6	EMM	M	3	O	10	3674		94				D	94-04-15	95-01-03	95-11-02	-	87.38
4.77E+08	5	SCN	M	61	J	1	8730	99070	90	4.00E+08	RHINELAN	CLN	D	95-07-24	95-07-24	95-09-05	37.76	30.21
3.15E+08	6	EMM	M	25	1	14	30928		54	6.00E+08	BOURBON	HSP	O	95-04-01	95-04-03	95-10-06	-	540.72
3.66E+08	6	SPF	F	50	J	1	7244	33490	90	4.00E+08	SINGH,	MD	O	95-10-10	95-10-10	95-12-01	91.62	91.62
3.72E+08	10	SPF	F	21	O	10	V681		94				O	95-12-13	95-12-13	96-01-03	85.28	68.22
3.72E+08	10	EMM	M	12	1	18	57400		1	4.00E+08	MARQUET	HSP	O	95-11-09	95-11-20	96-01-02	6,655.00	6,055.00
3.74E+08	10	EMM	M	44	1	9	4280	93010	2	4.00E+08	MARQUET	CLN	O	95-09-25	95-09-25	95-11-21	46.84	-
3.74E+08	10	EMM	M	20	1	9	4280	93010	2	4.00E+08	MARQUET	CLN	O	95-09-25	95-09-25	96-03-19	-46.84	-
3.78E+08	6	DAU	F	5	J	5	5243	7240	4	4.00E+08	CALDERW	DDS	O	95-06-20	95-06-20	95-07-11	904.00	723.20
3.84E+08	10	SPF	F	7	O	10	83921		94				O	95-03-05	95-03-05	95-04-06	66.86	53.48
3.85E+08	6	SPF	F	8	O	10	8470		94				D	93-08-31	93-08-31	95-04-05	-	-
3.88E+08	5	EMM	M	16	1	9	41011		2	4.00E+08	WAUSAU	HSP	D	94-12-29	95-01-30	95-04-07	-	-
3.89E+08	10	SPF	F	29	J	20	36616	76519	6	4.00E+08	GARRETT,	MD	O	95-03-07	95-03-07	95-06-08	-	-
3.90E+08	6	EMM	M	39	1	5	41401		2	4.00E+08	WAUSAU	HSP	O	95-10-17	95-10-22	95-11-14	20,746.70	20,070.15
3.93E+08	5	SPF	F	40	J	12	36720		90	4.00E+08	BATMIE,	OD	O	95-10-02	95-10-02	95-10-23	156.00	-

* = For confidentiality, these fields have been truncated in this report! They should not be truncated for data we receive!

kansans for Life

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TESTIMONY IN SUPPORT OF HB 2761-- CHIP funding for prenatal care
Feb.19, 2004
House Insurance Committee
Patricia Barbieri-Lightner
Madame chair and committee,

I am Kathy Ostrowski, Legislative Director of Kansans for Life, here in support of HB 2761, allowing funding of CHIP to extend to the child-in-the-womb.

Last year the federal department of Health & Human Services (HHS) approved extension of health care benefits to children-in-the womb under the S-CHIP program. Each state must address and legislate this need. H2761 does this for Kansans for Life supports this legislation for two reasons:

1) healthy birth outcomes enhanced through pre-natal care benefit both individuals and society
2) pregnant women who are ineligible for government assistance and feel financially driven to abortion, dramatically increases the risk of premature (including low and very low birth weight) babies in subsequent pregnancies.

In the first case, Kansas improves healthy births and avoids medical costs for an already existing pregnancy, thus helping to secure a threshold of child-bearing health. Secondarily, women will not unknowingly be damaging their future child-bearing capabilities.

All reputable scientific groups acknowledge the benefits of early and adequate pre-natal care to mothers, children and society. Certain populations are not accessing these pre-natal services due to cost. As an example, a pregnant woman with annual income of $ 26,680 for a family of 3, becomes ineligible if her household is reduced by one member. At that point, she is ineligible for pre-natal care from Medicaid. Her already-born child would be eligible for S-CHIP health care but not her in-the-womb child.[see attachment A,1-4]

From a purely economic viewpoint, costs for care in the womb are more than covered later by a variety of savings ensuing from healthy birth outcomes: Just a few examples:

1) delivery cost of an uncomplicated birth is generally 1/5 or less to that of one with prematurity, and very low birth weight. In the beginning, low-birthweight infants will have very expensive health care in the neonatal intensive care unit, and they can have ongoing problems that will require therapy and doctor visits, that can be expensive
2) Prematurity engenders a variety of physical conditions for which the state pays social services throughout the child's life,

House Insurance
Date: 2/19/04
Attachment # 7

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including:

3) intraventricular hemorrhage (bleeding in the brain) causes mental retardation; retinopathy of prematurity causes full or partial blindness.
4) The results of birth outcomes, like fetal alcohol syndrome ,impact the programs and cost of K-12 schooling

If the above wasn't enough reason, Kansans for Life is concerned that pregnant women are not informed that abortion raises the risk of prematurity and low weight births. Dr. Malcolm Potts has been a stout defender of elective abortion for many decades. In 1967 in Eugenics Review, Dr. Malcolm Potts conceded that induced abortion increased prematurity risk:

> "there seems little doubt that there is a true relationship between the high incidence of therapeutic abortion and prematurity. The interruption of pregnancy in the young (under seventeen) is more dangerous than in other cases." [Potts M. Legal Abortion in Eastern Europe. Eugenics Review1967;59:232-250]

Abortion raises the risk of
/low birth outcomes in subsequent pregnancies, both directly by physical damage that affects prematurity and by delayed age of next childbirth. In 2001 French researchers informed the public that women with more than 1 prior induced abortions multipled their risk of having a delivery at age 35 or above, which of course, conforms to common sense. The French researchers, [Henriet L, Kaminski M. Impact of induced abortions on subsequent pregnancy outcome: the 1995 French national perinatal survey.Br J Obst Gynaecol 2001;108:1036-1042.] also found that

1 prior induced abortion boosted **the relative risk of a preterm birth by 30% and 2 induced abortions elevated preterm delivery risk by 90%.**

In the May 2003 issue of the Journal of American Physicians and Surgeons, Rooney and Calhoun identified forty-nine (49) studies that found that prior induced abortions raised the odds of a later premature birth; [www.jpands.org/vol8no2/rooney.pdf] The Texas Department of Health began warning about the abortion-preterm risk in December . [www.tdh.state.tx.us/wrtk at page 17].
An extremely preterm baby has 38 times the risk of cerebral palsy as the general population of newborn.[see attachment C]

The Supreme Court in Polker & Maher in 1980, and subsequent court decisions, reinforce the right of the state to prefer childbirth over abortion in matters of funding. Poor pregnant women need to know their access to prenatal care will not be lost when the size of their household changes. Kansas should not put itself in the position of coercing an abortion by refusing temporary assistance to pregnant women.

Is Cerebral Palsy Ever a "Choice?"

Brent Rooney

"When Emily was ten months old, her doctor told us he thought we should have Emily evaluated for 'possible mild cerebral palsy,'" said Sandra. "I suddenly found myself at the beginning of a whole new emotional roller-coaster ride. My jaw dropped, my face felt immediately on fire, my eyes filled with tears, and my body began to shake all over. I clung tightly to my precious girl as I heard his words . . ."[1]

Cerebral palsy (CP) is a brain disorder resulting in improper balance, posture and movement. About 5,000 U.S. children under age 5 are yearly diagnosed as having CP.[2]

There are many unknowns about the risks for CP, and because of lawsuits against obstetricians, anyone identifying a new CP risk will be strongly challenged. In 1991, medical researchers did a review of previous studies and reported that very low birth weight newborns (those weighing less than 3 lbs., 5 oz.) had a whopping 38 times the risk of CP as normal weight newborns.[3]

At least 14 studies support the abortion-cerebral palsy link.

Thus, it is hardly surprising that a CP expert such as Dr. Elliot Gersh, developmental pediatrician and medical director of Mt. Washington Pediatrics Hospital, lists preterm birth as a major risk factor for CP.[2] The more preterm a birth, the higher the risk that the newborn will have a very low birth weight.

The Abortion Link

The connection between abortion and premature birth has been acknowledged as far back as 1967, when abortion supporter Dr. Malcom Potts wrote that "there seems little doubt that there is a true relationship between the high incidence of therapeutic abortion and prematurity. The interruption of pregnancy in the young (under 17) is more dangerous than in other cases."[4]

Professor Barbara Luke of the University of Michigan is a highly regarded author in the field of obstetrics. She notes that,

> If you have had one or more induced abortions, your risk of prematurity with this pregnancy increases about 30 percent. If they were done during the second trimester, after 14 weeks, your subsequent risk of prematurity is greater than if they had been done during the first trimester, before 14 weeks.[5]

At least 16 studies, including one published in the prestigious *New England Journal of Medicine*, support Luke's claim that a previous induced abortion elevates the subsequent risk of a premature birth.[6]

Most recently, a study of more than 61,000 Danish women, the largest study ever on premature births, found that women with previous induced abortions had double the risk of very preterm births (births before 34 weeks gestation) and almost double the risk of preterm births compared to women with no history of abortion. Women who had two previous "evacuation" type abortions had a 12 times higher risk of prematurity compared to women who had not had abortions.[7]

Luke has identified one mechanism that explains how abortion causes a risk of prematurity:

> The procedures for first-trimester abortion involve dilating the cervix slightly and suctioning the contents of the uterus. The procedures for second-trimester abortion are more involved, including dilating the cervix wider and for longer periods, and scraping the inside of the uterus.
>
> Women who had several second-trimester abortions may have a higher incidence of incompetent cervix—a premature spontaneous dilation of the cervix—because the cervix has been artificially dilated several times before this pregnancy.[5]

The risk of infection resulting from abortion may also explain the higher risk of premature births among post-abortive women. Researchers from the University of Wisconsin stated that "our findings indicate that an abortion in a woman's first pregnancy does not have the same protective effect of lowering the risk for intrapartum infection in the following pregnancy as does a live birth."[8]

In 1992, pro-choice researcher Dr. Janet Daling and her colleagues reported that if the previous pregnancy ended in induced abortion, the risk of intraamniotic infection increased by 140 percent.[9]

Pro-Abortion Silence

Despite the fact that studies have shown a significant increase in premature births among women who have abortions, most clinics don't list premature birth as a risk of abortion. In doing so, they've borrowed an argument from "Big Tobacco."

In 1954, following the publication of research showing that cigarette smoking increased the risk of lung cancer, the Tobacco Industry Research Committee placed a full-page ad in major newspapers entitled "A Frank Statement to Cigarette Smokers." Their message: the link between smoking and lung cancer was "not regarded as conclusive."

Was this statement true? Yes, but it implied that no warning of possible lung cancer risk should be given until "all" the evidence was in and was conclusive, a process that can take decades.

Smoking cigarettes is not curative for any disease nor is it necessary, so when the risk was first identified in 1954, cigarette packs should have carried warnings about possible lung cancer risk.

Just as abortion clinics refuse to inform women of the many studies showing a significant increased risk in breast cancer following abortion—insisting that the evidence is not yet "conclusive"—so they can also evade disclosing the risk of premature birth and CP by insisting the evidence is not yet "conclusive." Shades of spokesman "Joe Camel."

Crunching the Numbers

So how many cases of abortion-related CP occur yearly in the U.S.? If just 20 percent of U.S. women giving birth yearly had a previous induced abortion, that represents 800,000 women. The 1999 Danish study reported that a previous induced abortion doubles the risk of a very preterm birth. It is reasonable to assume that the risk of very low birth weight is also doubled. The 800,000 women will give birth to about 19,360 very low birth weight (VLBW) newborns, with about half of the cases (9,680) being due to a previous induced abortion.

Clinics aren't telling women abortion can cause cerebral palsy.

The odds of a VLBW newborn having CP is about 9.34 percent.[3] This yields 904 VLBW newborns with CP due to a mom's previous induced abortion. A similar calculation for moderately low birth weight (between 3 lbs, 5 oz. and 5 lbs., 8 oz.) births to women with prior induced abortions yields an additional 185 newborns with CP born to moms with prior induced abortions.

Grand total: 1,089 infants are born in the United States each year may develop CP because of reproductive injuries related to their mother's pervious abortions. This is only a ballpark estimate, but it is more than three times the number of victims (412) in the Tuskegee experiment, where patients were also denied the truth. And it happens every year.

The Higher Risk for Black Women

According to abortion apologist Dr. David A. Grimes, black women have 35.2 percent of all induced abortions in the U.S., although they comprise only about 12 percent of the U.S. female population. It has been a "mystery" to the vast bulk of medical researchers why black American women have about three times the risk of VLBW newborns compared to Caucasian women. Certainly, not all of this disparate impact on black women can be blamed on the tripled rate of induced abortions, but to assign no impact requires willing blindness.

In 1987 it was reported in the *New England Journal of Medicine* that black women with two previous induced abortions had a 91 percent higher relative risk of a subsequent preterm birth than black women with no induced abortions. The study noted that "black infants remain twice as likely as white infants to die during the first year of life."[6]

VLBW newborns have over 90 times the mortality risk in their first year of life compared to normal weight newborns.[10] In a study of children in Atlanta, Georgia between 1985 and 1987, it was reported that 10-year-old black children had a 30 perc higher prevalence of CP than did 10-year-old white children.

This disparate rate of VLBW babies for black American women has ominous implications for CP rates among black infants. Which black leader will start a campaign to lower the rate of CP by informing black women of the health risks of elective abortion?

A Malpractice Lawyer's Dream?

Every year parents of infants with CP sue obstetricians, believing that errors of commission or omission contributed to their child's malady. At least some medical researchers believe that some cases of CP are caused by problems occurring during delivery.

This article does not dispute this very real possibility. What is virtually unknown by malpractice lawyers and parents of CP children, however, is that the actions of another doctor may have boosted their child's CP risk when he or she performed an induced abortion on the mother in the past.

Successful CP suits can result in damage awards exceeding one million dollars. If parents are considering suing the obstetrician who delivered their child, they should also consider adding the name of the abortionist(s) to those sued. The risk for subsequent preterm births is rarely, if ever, listed on abortion clinic consent forms, nor is this risk verbally communicated to young women considering surgical abortions. It is even less likely that the consequences of preterm births are explained to women: neonatal death, cerebral palsy, and other developmental handicaps.

One thing that medical malpractice lawyers love to see is an *unconsented* risk; that is, a risk about which the patient was not informed and therefore did not consent to accept as a risk. Also, since induced abortions are legally considered to be elective procedures, there is no justification for withholding information about risks for which the evidence is still not absolutely conclusive.

The bottom line is that elective induced abortion is a credible risk factor for CP, but this has never been disclosed to women. The vast majority of U.S. adults believe patients have a right to give informed consent about medical decisions, yet that right is being denied at abortion clinics. Some jury members may be outraged by this fraud of not disclosing risks to women of prematurity and CP.

In this case, the result of this non-disclosure is that newborns are put at elevated risk for CP. No wonder some groups talk about "choice" but not about *informed* choice.

Brent Rooney has written major articles on breast cancer prevention for the highest circulation health magazine in Canada, ALIVE. *Citations to other studies linking CP and abortion can be found on his web site at www.vcn.bc.ca/~whatsup.*

A1

Poverty Guidelines

Selected SRS Services	Percent of 2003 Federal Poverty Level	Annual Income Guidelines for 1-5 Member Households HH1	HH2	HH3	HH4	HH5
TAF and GA-Cash & Medical	32%	$2,874	$3,878	$4,883	$5,888	$6,893
Elderly/Disabled Persons on SSI-Medical	72%	6,466	8,726	10,987	13,248	15,509
Children Age 6-18-Medicaid/Waivers	100%	8,980	12,120	15,260	18,400	21,540
	105%	9,429	12,726	16,023	19,320	22,617
	110%	9,878	13,332	16,786	20,240	23,694
	115%	10,327	13,938	17,549	21,160	24,771
	120%	10,776	14,544	18,312	22,080	25,848
	125%	11,225	15,150	19,075	23,000	26,925
Food Assistance/ Energy Assistance	130%	11,674	15,756	19,838	23,920	28,002
Children Age 1-5-Medicaid	133%	11,943	16,120	20,296	24,472	28,648
	135%	12,123	16,362	20,601	24,840	29,079
	140%	12,572	16,968	21,364	25,760	30,156
	145%	13,021	17,574	22,127	26,680	31,233
Pregnant Women & Infants-Medicaid	150%	13,470	18,180	22,890	27,600	32,310
	155%	13,919	18,786	23,653	28,520	33,387
	160%	14,368	19,392	24,416	29,440	34,464
	165%	14,817	19,998	25,179	30,360	35,541
	170%	15,266	20,604	25,942	31,280	36,618
	175%	15,715	21,210	26,705	32,200	37,695
	180%	16,164	21,816	27,468	33,120	38,772
Child Care Subsidy	185%	16,613	22,422	28,231	34,040	39,849
	190%	17,062	23,028	28,994	34,960	40,926
	195%	17,511	23,634	29,757	35,880	42,003
Children's Health Insurance Program	200%	17,960	24,240	30,520	36,800	43,080

Information contained in this chart is intended to be general and is subject to change.
For specific eligibility requirements, please check with your Area SRS Office.

MEDICAL ASSISTANCE
CONSUMERS BY PROGRAM

Fiscal Year 2003

PROGRAM	July	August	Septembe	October	Novembe	Decembe	January	February	March	April	May	June	Fiscal Year-To-Date Monthly Average	Fiscal Year-To-Date Unduplicate Total
SSI Aged	5,863	5,964	5,663	5,966	6,068	6,036	6,414	6,392	6,272	6,436	6,153	5,603	6,069	7,710
SSI Blind/Disabled	27,733	28,543	27,841	28,538	28,875	28,910	29,844	29,608	29,738	30,440	29,911	29,151	29,094	36,397
Temp. Assist. for Families	503	655	408	353	318	343	416	300	569	446	1,258	950	543	3,593
TAF Extended Medical	4,502	4,860	9,437	8,860	9,044	9,501	10,870	9,811	9,722	6,691	10,627	9,806	8,644	21,626
Caretaker Medical	20,684	23,076	44,414	44,492	47,171	48,714	53,413	49,913	50,225	33,401	53,921	49,991	43,285	85,615
GA Disabled	3,060	3,292	3,111	3,338	3,421	3,437	3,628	3,555	3,615	4,039	4,031	3,828	3,530	7,145
GA Reintegration	67	63	49	73	63	56	71	68	79	101	95	54	70	303
FC-SRS Total	3,359	4,074	3,813	4,117	4,109	4,145	4,437	4,229	4,328	4,751	4,408	3,957	4,144	8,334
FC-JJA Total	1,338	1,409	984	1,248	1,015	1,049	1,127	1,024	2,493	1,281	1,072	998	1,253	3,721
Adoption Support	1,679	2,025	1,979	2,259	2,257	2,405	2,591	2,508	2,502	2,698	2,404	2,238	2,295	4,048
Med. Needy Aged	15,992	16,203	15,777	16,311	16,511	16,618	17,488	17,114	16,642	17,218	16,241	15,607	16,477	22,486
Med. Needy Blind/Disabled	9,944	10,495	10,050	10,705	10,975	11,009	11,782	11,641	11,559	12,013	11,442	10,929	11,045	15,971
QMB/QWD	1,465	819	416	531	521	631	1,725	2,352	2,842	3,161	2,443	2,305	1,601	5,488
Med. Needy Families	393	544	494	609	627	675	783	705	703	790	734	528	632	2,317
Spec PW/Children	39,208	43,406	77,565	76,185	78,811	80,167	87,507	79,454	78,411	57,568	86,297	80,355	72,078	148,620
Refugee Total	2	2	3	2	2	4	6	7	4	5	7	3	4	14
SOBRA	183	324	268	269	256	234	453	288	366	412	327	223	300	2,117
MA Child in Institution	43	55	51	80	67	70	90	91	74	91	75	78	72	258
Special Tuberculosis	0	1	3	0	2	1	5	3	5	6	5	2	3	14
Breast and Cervical Cancer	29	29	30	35	40	48	46	44	54	63	61	51	44	77
Unassigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**133,889**	**142,295**	**199,975**	**200,140**	**205,831**	**209,278**	**225,970**	**213,584**	**214,123**	**173,580**	**222,784**	**210,883**	**196,028**	**311,814**

Note: Consumers may be counted in more than 1 Program Area. Totals are unduplicate

MEDICAL ASSISTANCE
EXPENDITURES BY PROGRAM

Fiscal Year 2003

PROGRAM	July	August	September	October	November	December	January	February	March	April	May	June	Fiscal Year-To-Date Total	Fiscal Year-To-Date Monthly Average
SSI Aged	$5,200,286	$6,499,081	$5,393,769	$6,540,290	$6,329,971	$5,509,430	$7,289,496	$6,051,062	$5,358,525	$6,587,204	$5,685,046	$4,180,951	$70,625,110	$5,885,426
SSI Blind/Disabled	$27,563,216	$36,197,342	$30,951,670	$38,074,524	$35,890,288	$32,473,956	$41,865,145	$34,820,885	$31,979,374	$40,745,710	$33,481,844	$24,720,866	408,764,820	$34,063,735
Temp. Assist. for Families	75,392	61,844	70,073	117,048	87,110	54,473	26,724	37,874	111,981	30,793	25,972	19,424	718,708	$59,892
TAF Extended Medical	547,329	788,848	2,509,842	1,460,320	1,393,399	1,613,002	1,723,596	1,409,261	1,360,308	1,692,170	1,434,430	1,166,414	17,098,919	$1,424,910
Caretaker Medical	3,934,927	4,889,328	13,668,743	7,858,842	8,865,577	9,907,264	11,419,628	9,810,292	9,143,879	11,142,170	9,661,033	7,987,455	108,289,139	$9,024,095
GA Disabled	1,116,030	2,128,704	1,472,089	1,563,072	1,864,072	1,712,724	2,306,527	1,605,976	1,523,382	2,016,427	1,651,705	1,125,369	20,086,077	$1,673,840
GA Reintegration	56,205	84,740	24,803	37,060	46,529	32,609	50,589	42,130	39,560	70,254	54,506	26,609	565,594	$47,133
FC-SRS Total	1,570,708	2,151,887	1,792,470	2,072,085	2,375,899	2,412,829	2,727,696	2,237,239	2,307,697	3,384,185	2,329,137	1,869,904	27,231,736	$2,269,311
FC-JJA Total	1,849,092	2,331,908	1,834,589	2,264,215	2,345,340	2,074,584	2,368,974	1,933,243	3,216,916	2,661,496	2,046,253	2,151,470	27,078,082	$2,256,507
Adoption Support	778,897	1,065,184	937,754	1,117,246	944,160	1,171,893	1,383,985	1,136,826	1,174,948	1,350,167	1,154,521	1,022,717	13,238,300	$1,103,192
Med. Needy Aged	28,851,809	35,944,609	31,610,604	37,199,138	32,220,887	30,123,291	39,476,590	32,443,301	30,236,637	37,109,987	31,246,387	28,980,469	395,443,710	$32,953,642
Med. Needy Blind/Disabled	18,200,591	23,514,455	20,380,885	25,820,570	22,990,881	22,168,560	26,873,056	21,674,362	20,269,136	26,204,682	21,830,299	16,224,807	266,152,284	$22,179,357
QMB/QWD	460,516	461,534	506,674	466,293	513,449	542,540	737,054	671,801	820,167	832,815	706,152	637,058	7,356,053	$613,004
Med. Needy Families	369,853	177,062	182,876	229,378	228,243	211,541	323,271	235,285	296,995	260,484	170,371	392,310	3,077,670	$256,472
Spec PW/Children	5,481,316	8,456,364	24,203,532	15,102,932	14,748,812	15,034,147	19,038,521	15,254,344	14,915,253	17,805,640	15,922,323	13,073,137	179,036,321	$14,919,693
Refugee Total	149	68	97	121	397	571	4,484	883	496	696	938	275	9,175	$765
SOBRA	278,393	656,113	505,210	458,007	430,087	408,001	703,129	427,275	569,504	557,793	487,906	278,936	5,760,354	$480,030
MA Child in Institution	46,926	85,895	57,160	151,572	111,112	151,928	230,349	143,930	117,692	204,649	192,642	205,510	1,699,366	$141,614
Special Tuberculosis	0	1,300	19,563	0	52,753	9,705	68,504	30,470	11,646	52,018	-4,977	792	241,774	$20,148
Breast and Cervical Cancer	25,877	112,117	39,764	54,656	62,074	100,507	107,756	91,108	57,211	107,394	75,417	58,549	892,431	$74,369
Hipps, Unassigned	-45,132	-54,217	-44,471	7,512	-37,866	-22,686	-99,578	19,789	-114,320	-58,246	-57,328	-61,346	-567,888	-$47,324
MMIS Expenditure Total	**$96,362,380**	**$125,554,167**	**$136,117,696**	**$140,594,882**	**$131,463,175**	**$125,690,871**	**$158,625,497**	**$130,077,337**	**$123,396,986**	**$152,758,488**	**$128,094,579**	**$104,061,675**	$1,552,797,733	$129,399,811
Non Client Specific Expenditures	**$30,364,742**	**-$7,393,277**	**$24,165,114**	**$8,195,880**	**$44,074,643**	**$6,853,876**	**-$2,725,702**	**$7,589,667**	**-$1,195,923**	**$622,447**	**$26,967,038**	**$991,954**	$138,510,460	$11,542,538
Grand Total	**$126,727,122**	**$118,160,890**	**$160,282,810**	**$148,790,762**	**$175,537,818**	**$132,544,747**	**$155,899,794**	**$137,667,004**	**$122,201,064**	**$153,380,935**	**$155,061,618**	**$105,053,629**	**$1,691,308,193**	**$140,942,349**

Medicaid Medical Health Care

Statistic	FY 2002 Actual	FY 2003 Actual	FY 2004 GBR	FY 2005 GBR
Average Monthly Persons	211,585	230,299	243,115	257,121
Expenditures	$803,403,000	$905,578,789	$1,039,048,595	$1,161,906,968

SCHIP

Statistic	FY 2002 Actual	FY 2003 Actual	FY 2004 GBR	FY 2005 GBR
Average Monthly Persons	25,703	28,945	31,800	35,000
Expenditures	$43,295,628	$47,853,226	$51,563,117	$56,991,390

Program Management Responsibilities

In addition to funding health care services, SRS through Medical Policy/Medicaid, is the single State agency responsible for the integrity of all Medicaid and SCHIP funded programs in Kansas. Not only does the Medicaid program serve as a major source of federal financing for other programs in Kansas, Medical Policy/Medicaid assists other State agencies in complying with Medicaid rules and regulations, including the Kansas Department on Aging, the Juvenile Justice Authority, the Kansas Department of Health and Environment, and the State Department of Education. This responsibility requires collaboration among several SRS divisions and State agencies. It also requires constant communication with consumers, physicians, dentists, pharmacists, managed care and long-term care providers, and myriad of others who play a very important role in the success of this critical program.

MENTAL HEALTH (MH)

MH purchases services for individuals and families who experience mental illness. To achieve this goal, SRS embraces the following values:

- People have the right to make informed choices about their life based on their individual preferences;
- Consumer and family voice is essential and directive;
- People deserve effective state-of-the-science treatment;
- Treatment must be respectful and empowering to the individual;
- With effective treatment and services, people can experience a personal process of recovery from mental illness; and
- Services must be provided in the most integrated, safest, flexible and accessible environment with a focus on community-based supports.

MH purchases and monitors services provided to adults with a Severe and Persistent Mental Illness (SPMI) and children with a serious emotional disturbance (SED). These groups of persons, defined by contract, make up the "target population" for MH services.

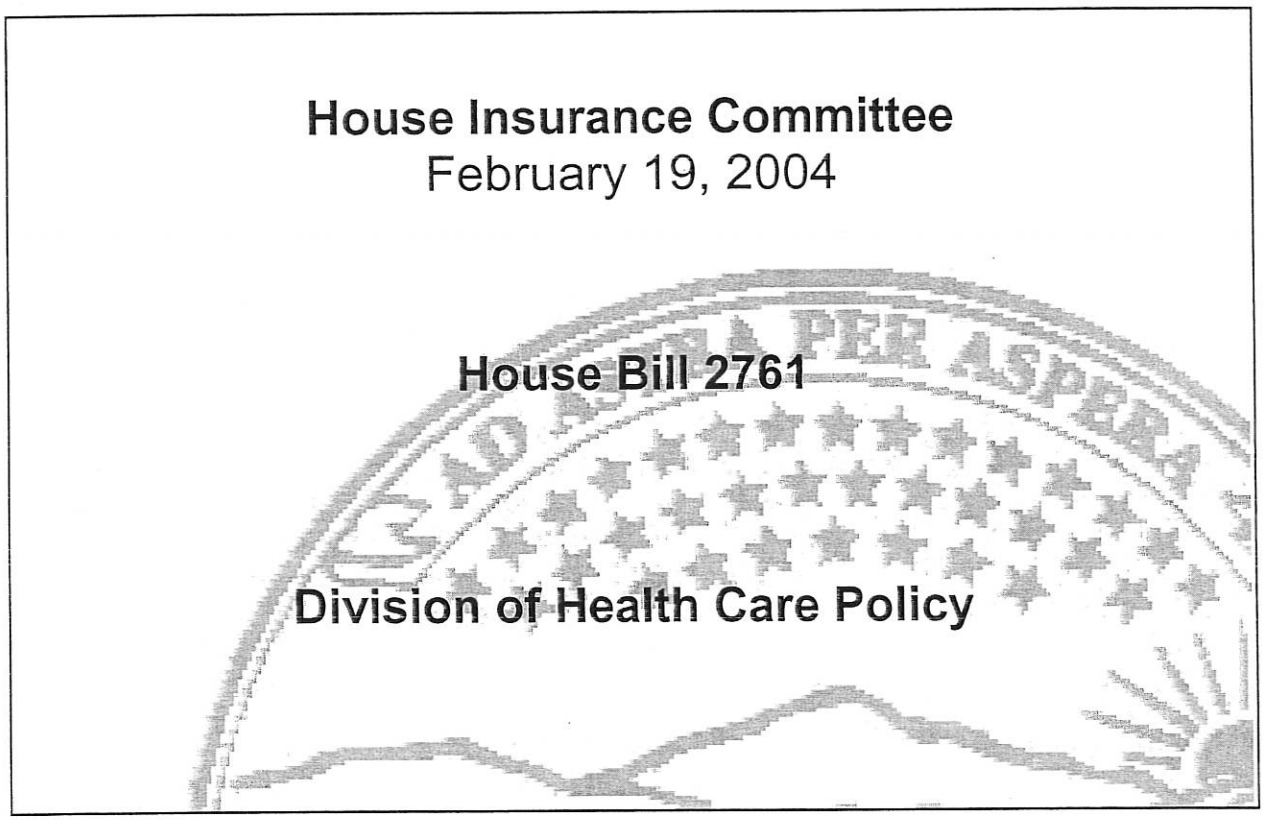
Services for adults with SPMI and children with a SED are purchased primarily through 27 CMHCs and their affiliates. The two licensed affiliates specialize in services to children and their families.

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

House Insurance Committee
February 19, 2004



House Bill 2761

Division of Health Care Policy

For additional information contact:
Public and Governmental Services Division
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House Insurance
Date: 2/19/04
Attachment # 8

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

House Insurance Committee
February 19, 2004

House Bill 2761

SRS submits this written testimony in regard to HB 2761. This bill would require the State to extend coverage in the State Children's Insurance Program (SCHIP) to unborn children of pregnant women who do not meet SCHIP eligibility criteria – because they are older than 19 – and who do not meet the income standard for Medicaid.

SCHIP (Title XXI) is a Federal/State partnership created to expand health insurance coverage to children whose families are not eligible for Medicaid because their incomes are too high. Federal regulations refer specifically to targeted low income children who reside in families with incomes below 200 percent of the Federal Poverty Level (FPL) or incomes 50 percent higher than a state's Title XIX Medicaid eligibility requirement. In Kansas, SCHIP is available statewide to children from birth to age 19 who live in families with incomes up to 200 percent of FPL. These children must be residents of Kansas.

Children are ineligible for SCHIP if they are currently covered by other health insurance or are eligible for Title XIX Medicaid coverage. To be eligible for SCHIP coverage, families above 150% of the poverty level must agree to pay a monthly premium. Children are ineligible for SCHIP coverage if they are eligible for health care coverage under the Kansas Group Insurance Program, if they are an inmate in a public correctional institution, or if they are a patient in an institution for mental diseases. Eligibility is determined annually and twelve months of continuous eligibility is applicable to both Title XIX and SCHIP enrollees even if family income increases above the income threshold during that time period.

SCHIP currently covers pre-natal care for pregnant women up to age 19 who meet the SCHIP eligibility requirements stated above. In October 2002, a revision to the Federal SCHIP regulations was issued to expand the definition of "targeted low-income children" to allow states the option of making individuals between conception and birth eligible for coverage. This permits states to decide to make medical services available to benefit unborn children independent of the mother's eligibility status, however, SCHIP funds may not be spent when payment for such medical services could be made due to the mother's eligibility for Medicaid. Screening procedures for SCHIP must identify any applicant or enrollee who would be eligible for Medicaid services based on the eligibility of his or her mother. If a mother is eligible for Medicaid, the unborn child cannot be eligible for SCHIP.

Testimony – February 19, 2004
House Insurance Committee

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House Insurance Committee
Testimony in Support of House Bill 2761

Chairman Barbieri-Lightner and members of the committee:

Thank you for the opportunity to testify in support of House Bill 2761. My name is Beatrice Swoopes, and I am the Associate Director of the Kansas Catholic Conference, the public policy office for the Catholic Church in Kansas.

House Bill 2761 would change the current wording in Kansas statutes covering children eligible for the State Children's Health Insurance Program (SCHIP) from "zero to 19 years of age" to "conception to 19 years of age". This change would put Kansas in compliance with the Federal Administrative Rule governing this program.

Our support is based on the importance of ensuring adequate health care for children, both before and after birth. This change reflects the medical reality that the life of a child begins before birth at conception, and is thoroughly consistent with precedent: according legal significance to, and protecting, the life of the unborn child.

The State Children's Health Insurance Program was created in 1997 to expand access to health care for low-income children less than 19 years of age. Ensuring a child's health and well-being is an undertaking that begins before birth – the health of a child in utero directly impacts that same child's health once he or she is born.

Recognizing that fact, over the past decade states and the federal government have sought ways to extend health coverage for prenatal services for low-income pregnant women and their unborn children, through both the Medicaid and SCHIP programs. Several bills on the federal level to amend SCHIP to include pregnant women have been introduced in Congress and are awaiting action. To accomplish the same end in the absence of legislative change, the Administration used its rulemaking authority to clarify that the regulatory definition of a child eligible for SCHIP coverage includes children "under the age of 19 including the period from conception to birth," thereby giving States the option to provide pre-natal health care coverage under SCHIP to unborn children and their mothers.

House Insurance
Date: 2/19/04
Attachment # 9a

giving States the option to provide pre-natal health care coverage under SCHIP to unborn children and their mothers.

A recent Performance Audit Report (June 2003) regarding Low-Birth weight and Premature Babies in Kansas bears out the importance of pre-natal health care coverage. I refer you to this report, which is attached to my testimony.

The report's findings indicate that low-birthweight and premature babies are very costly to the State:

> "Medicaid paid at least $54.1 million for babies born in 2000 during their first year of life. Of that amount, $19.5 million (36%) was spent for services to low-birthweight babies, who represented slightly less than 10% of the Medicaid babies born that year. On average, low-birthweight and premature babies were about 5 times more expensive during the first year of life than normal-birthweight babies - $16,000 each, compared to $3,100."

The report concludes that:

> "Low-birthweight and premature babies cost the State's Medicaid program more than 5 times as much as normal birthweight babies during the first year of life, and many of these children will have long-term health problems that will place continuing demands on the medical and education systems."

The United States Conference of Catholic Bishops believes that every human being has the right to quality health services, regardless of age, income, illness or condition of life, and has long supported access to prenatal care for pregnant women and their babies. The Conference wrote in its 1991 document, ***Putting Children and Families First***:

> "Beginning with our children and their mothers, we must extend access to quality health care to all our people. Quality and accessible prenatal care is essential for healthy children. There can be no excuse for the failure to ensure adequate health care and nutrition for pregnant women. Nothing would make a greater contribution to reducing infant mortality than progress in this area."

Because prenatal care is essential for the health of both the child and the mother, and more accessibility would clearly help reduce costs in this area to the state, the Kansas Catholic Conference urges you to support passage of H.B. 2761.

Thank you,

Beatrice Swoopes
Associate Director

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of the Incidence and Cost of Low-Birthweight and Premature Babies in Kansas

Of babies born in 2000, 7.6% nationwide and 6.9% in Kansas were low-birthweight–that is they weighed less than 5 pounds, 8 ounces at birth. These babies have high financial and social costs, as do premature babies, who may or may not be low-birthweight. About one-third of all births in Kansas are Medicaid-related, meaning that either the mother or the baby is a Medicaid recipient. Those babies are more likely to be born prematurely or have a low birthweight than other babies in Kansas.

..... page 5

Low-birthweight and premature babies have both immediate and long-term problems. *These babies often are born with respiratory problems, heart problems, infections, or feeding and digestive problems. They also are more likely to have lifelong problems, such as cerebral palsy or chronic lung disease. The March of Dimes has estimated lifetime medical costs for a premature baby at $500,000.*

..... page 6

Low-birthweight and premature babies are very costly to the State. *Medicaid paid at least $54.1 million for babies born in 2000 during their first year of life. Of that amount, $19.5 million (36%) was spent for services to low-birthweight babies, who represented slightly less than 10% of the Medicaid babies born that year. On average, low-birthweight and premature babies were about 5 times more expensive during the first year of life than normal-birthweight babies— $16,000 each, compared to $3,100. Much of the difference was due to hospitalization expenses: on average, low-birthweight babies were in the hospital 12 days, or 6 times longer than normal-birthweight babies at 2 days. The differences are even more dramatic between normal-birthweight babies and very low-birthweight babies, those born weighing less than 3 pounds, 5 ounces, who averaged 28 days in the hospital.*

..... page 6

Question 1: Does It Appear That a Lack of Prenatal Care Is the Major Factor Contributing to High Medicaid Costs Associated With Low-Birthweight or Premature Babies in Kansas?

The literature says that a lack of prenatal care is one of many factors that can increase the risk of poor birth outcomes, thereby increasing costs. *Research on the effectiveness of medical prenatal care has been mixed– some studies have shown it can reduce the incidence of low-birthweight babies, while other have shown it has no proven impact on birth outcomes. However, comprehensive prenatal care, which includes both medical visits and "wrap-around" services, such as nutrition counseling or smoking cessation, has proven to be much more effective at improving birth outcomes.*

Other factors identified as increasing the risk of poor birth outcomes often relate to a woman's personal choices or characteristics. These include whether she smokes or drinks alcohol, as well as her weight gain, age, race, and marital status. Prenatal care can address some of the factors, but not others.

..... page 11

Most Medicaid mothers in Kansas got medical prenatal care, although they were much less likely to get it than non-Medicaid mothers. *Currently, the only source of this data comes from the birth certificate filled out at the time of birth. These data showed the following:*

..... page 13

- *81% of the women who gave birth in Kansas during 2000 reported getting adequate or better medical prenatal care*
- *Medicaid mothers were much less likely to have received adequate or better prenatal care than non-Medicaid women– 72% compared with 87%.*
- *About 79% of the mothers of low-birthweight babies got adequate or better prenatal care.*

Very few Medicaid mothers (1.4%) got no medical prenatal care at all, and on average their babies cost Medicaid about $3,000 to $8,000 more than those whose mothers got even minimal care. Low-birthweight babies cost more than normal-birthweight babies regardless of the amount of prenatal care their mothers received.

In general, the more prenatal care Medicaid mothers received, the lower their incidence of low-birthweight babies. *Women who got no or inadequate prenatal care had a much higher incidence of low-birthweight babies than women who received adequate prenatal care (29% low-birthweight rate for women who received no prenatal care versus 5% for women with adequate prenatal care). The only exception was mothers who received the most intensive care. They had a high rate of low-birthweight babies, suggesting medical problems had been identified during the pregnancy that required a higher level of care.*

..... page 16

Mothers of Medicaid low-birthweight babies had a higher prevalence of many of the other risk factors associated with poor birth outcomes. *In terms of personal characteristics, they were more likely to smoke, to be younger than age 17 or older than 34, to be black, to have had a previous premature birth, to be underweight, and to have had a low weight gain during pregnancy. They were far more likely than mothers of normal birthweight babies to have had medical problems during the pregnancy, although the incidence of medical problems in both groups was very low.*

..... page 17

Question 2: What Programs Are Available To Provide Prenatal Care for Mothers Who Can't Otherwise Afford It, And What Is the Cost of Those Programs?

The State has several programs through SRS and KDHE that serve pregnant women. *However, the Maternal and Infant Program, administered by KDHE is the only program that focuses primarily on prenatal*

..... page 19

care. Several other programs, such as WIC and Healthy Start, also serve pregnant women and contribute toward low-income women receiving prenatal care, but they aren't designed as solely prenatal care programs.

KDHE's Maternal and Infant Program is part of the broader federal Maternal and Child Health block grant. Local health departments have the option of offering the Maternal and Infant Program; 71 counties offered it in 2003. Each county's program varies, ranging from referral services only, to the provision of comprehensive prenatal care including medical visits.

The Pregnancy Maintenance Initiative grant program, which provided prenatal care services for women to help them carry their pregnancy to term, was eliminated in the beginning of fiscal year 2003.

SRS and KDHE currently administer other programs that may serve pregnant women, such as mental health services and substance abuse services. However, these programs are not targeted specifically for pregnant women. And even though research has shown that smoking is one of the most serious risk factors for poor birth outcomes, neither SRS nor KDHE administer any smoking cessation programs directed specifically at pregnant women.

The State spends very little outside of Medicaid on programs for pregnant women. *The State's share of the cost for funding prenatal services through the Medicaid Program was nearly $15 million in fiscal year 2002. In contrast, the State spends only slightly more than $2 million a year on other programs that provide prenatal care services to low-income women.*

..... page 23

Question 3: Why Are Some Low-Income Women Not Getting Prenatal Care Services?

Local health officials cited numerous reasons why some Kansas women don't get prenatal care services. *We surveyed officials from all 105 local health departments (90% responded), reviewed client files, and spoke with other experts. Two over-riding reasons emerged: women can't or don't use the services that are available, or needed services simply aren't always available.* page 24

..... page 24

Pregnant women can't or don't always use the prenatal services that are available. *County health officials cited financial barriers as the biggest reason why low-income women don't use available prenatal services. They voiced 2 concerns: some women earn too much money to qualify for Medicaid but not enough to afford private health insurance or pay for prenatal care themselves, and many non-citizens with low incomes aren't eligible for Medicaid. However, the State may become responsible for medical costs for their children either because, with the birth of an additional child, a family may become eligible for Medicaid or the children's health insurance program, or because babies born in this country to immigrant parents are U.S. citizens and may qualify for Medicaid.*

Personal attitudes or situations also may limit use of prenatal care services, even when women know those services are available. Kansas experts we spoke with said stress, social isolation, and poverty often prevent pregnant women from seeking prenatal care. County health officials cited both ignorance about services and personal attitudes (e.g., a woman doesn't want to be pregnant and is ambivalent about the baby) as important reasons why women don't use services.

..... page 27

Some women don't get prenatal care because needed services aren't always available. *Local officials identified the 4 most critical prenatal care services that either aren't available or aren't available in sufficient quantity where they live: medical services, smoking cessation programs, alcohol and drug abuse counseling, and case management services. Almost 20% of survey respondents said medical services were not available in their areas at all. "Enabling" services such as transportation and interpreters often aren't available, and local officials aren't always aware of ways to access those services. For example, 12 of 37 health departments we followed up with weren't aware that Medicaid could pay for transportation to medical services.*

..... page 30

The State isn't doing all it can to educate pregnant women about the benefits and availability of prenatal care. *KDHE currently has no marketing campaign to promote the importance of prenatal care, at least in part because of shortages of staff and money. SRS publicizes the availability of public health insurance overall, but it doesn't target pregnant women and the services available to them. Local agencies are responsible for marketing their Maternal and Infant programs. They told us they have little incentive to market the programs because they can't handle any more clients.*

Question 4: Is KDHE Collecting and Reviewing the Types of Information Necessary To Know Whether Prenatal Care Programs It Offers in Kansas Are Effective In Reducing the Incidence and Cost of Premature and Low-Birthweight Babies?

..... page 33

KDHE doesn't receive the types of information it would need to fully assess the effectiveness of the Maternal and Infant Program. *A full evaluation of effectiveness would require information on the types of prenatal medical and wrap-around services women were referred to, the types of services women actually received, birth outcomes, and personal characteristics about these women that could be considered risk factors for low-birthweight or premature babies. KDHE would need to compare factors of individual program participants against those of women who didn't participate.*

Currently, KDHE collects only summary information for the women who participate in local Maternal and Infant programs: the numbers of live births, premature births, low-birthweight babies, fetal deaths/stillbirths, and

infants who died in their first year of life. Officials apparently have done only informal evaluations of the Program's effectiveness using the available data, comparing rates for Program participants against those for the counties as a whole and looking for trends. Private prenatal programs we contacted are generally tracking the same types of information KDHE receives, and specialists had few suggestions for comprehensive evaluation strategies.

Using existing birth certificate data, KDHE could do more to identify and help target areas with high risk factors or poor birth outcomes. *It could use that data for the population as a whole, not just participants in the Maternal and Infant Program. Using that information, KDHE could pinpoint where need is greatest, identify the prevalent risk factors that can be affected by interventions, and encourage action to address needs and risk factors.*

..... page 36

KDHE officials also said they would like to see Kansas participate in the national Pregnancy Risk Assessment Monitoring System (PRAMS) developed by the Centers for Disease Control and Prevention. This survey, sent to a sample of new mothers, asks about some factors not included in the birth certificate, such as domestic violence and the amount of alcohol consumed before and during the pregnancy. Kansas law currently prohibits using information from birth certificates for survey purposes. KDHE also is involved in a project that will link data from birth certificates, Medicaid, and the WIC program, to determine whether babies of women who participate in those programs have better birth outcomes.

Conclusion: *Low-birthweight and premature babies cost the State's Medicaid program more than 5 times as much as normal-birthweight babies during their first year of life, and many of these children will have long-term health problems that will place continuing demands on the medical and education systems.*

..... page 38

There's no simple solution to reducing the incidence of poor birth outcomes – most women who have premature or low-birthweight babies have many medical, socio-economic, or lifestyle risk factors, including lack of prenatal care. Although there's conflicting research about the extent to which prenatal care improves birth outcomes, our audit work found that medical expenses were much higher for those Medicaid babies whose mothers received little or no prenatal care. This suggests that prenatal care does help identify and address problems, and thereby lower the State's costs for children covered by Medicaid.

The State needs to improve its system for helping ensure low-income women receive adequate, comprehensive prenatal care. Most of the spending in Kansas for prenatal care comes from Medicaid and the Women, Infants, and Children (WIC) nutrition program. Relatively little is spent on wraparound-type services, which have been shown to be the most likely to make a difference in birth outcomes. In addition, low-income pregnant women's access to basic medical services appears to be lacking

in many parts of the State, as is their access to smoking cessation and substance abuse services. Marketing of the State's prenatal services (both through the Maternal and Infant Program and through Medicaid) is inadequate.

Experts agree it's difficult to evaluate the effectiveness of prenatal care programs, and currently KDHE does little to determine whether its prenatal care program in particular, or all prenatal care in the State, is effective at reducing the incidence of poor birth outcomes. Increased efforts to pinpoint where the need for care is the greatest could help better direct the limited amount of money the State spends on prenatal care.

Recommendations: *To ensure that as many women as possible know about available prenatal care programs, KDHE should increase its educational marketing campaigns and encourage local health departments to increase their efforts as well, seeking additional funding if necessary. KDHE and SRS officials should work together to reduce the number of low-income women who don't get services because of transportation problems. To ensure that low-income pregnant women who might qualify for Medicaid apply for the program, SRS should do more to clearly promote prenatal services in its publications. To better identify where needs are greatest, KDHE should do more analysis of available birth certificate information to pinpoint areas of greatest need, and then work with local officials and the Legislature to respond to those problems. KDHE also should propose legislation that would modify restrictions in State law and allow KDHE to survey new mothers.* ..... page 38

APPENDIX A: *Scope Statement* ..... page 41

APPENDIX B: *Itemized Medicaid Cost Data* ..... page 44

APPENDIX C: *Agency Responses* ..... page 45

This audit was conducted by LeAnn Schmitt, Chris Clarke, Jill Shelley, and Katrin Osterhaus. Cindy Lash was the audit manager. If you need any additional information about the audit's findings, please contact Ms. Schmitt at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.

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19 February 2004

Rep. Patricia Barbieri-Lightner, Chair
House Insurance Committee
300 SW 10th Ave., Room # 115S
Topeka, Kansas 66612-1504

Dear Representative Barbieri-Lightner:

My name is Julie Burkhart and I'm the Executive Director of ProKanDo, which is a state-wide political network. I wish to thank you Representative Barbieri-Lightner for the opportunity to speak with members of the committee regarding my opposition to HB 2761.

Currently, children in Kansas are covered through state health insurance from birth until nineteen years of age. HB 2761 seeks to amend the status quo to cover Kansas children from the time of conception instead of from the time of birth. There are several reasons why this is not needed and in fact, could actually do more harm than good.

First, state insurance already covers pre-natal care for a pregnant woman; therefore, separate coverage of the fetus is not necessary. In fact, this bill could actually do a great deal of harm by pitting women's needs against the program's patients (the pregnancy). For example, would a pregnant woman with cancer be able to access potential life-saving treatment, since the treatment could harm the pregnancy? In addition, the effects of many prescription drugs on a fetus have not been exhaustively studied. Under this bill the fetus's health could be put above the woman's decision to take certain prescription drugs.

Second, social service programs are already severely under funded; adding another burden such as this is simply not feasible. The administrative costs and paperwork of making the pregnancy separate from the woman would be nothing more than a burdensome addition, since the woman can already receive pre-natal care. If the goal of HB 2761 is to maintain the highest health standards for a woman's pregnancy, then why not propose expanding Medicaid to fund those who might fall through the cracks between Healthwave and Medicaid?

Lastly, this bill is simply another attempt by anti-choice advocates to establish a fetus as a person under Kansas law by establishing a pregnancy, from the moment of conception, as a separate beneficiary of government programs. Since anti-choice parties continue to be unsuccessful at overturning *Roe v. Wade,* they resort to back-door attempts, such as HB 2761, to further their political agenda. The long-term goal of this bill is to make abortion illegal by directly challenging the *Roe v. Wade* language.

We unequivocally support the state's coverage of pre-natal care for women who cannot afford it. We also support expanding coverage under Medicaid, which can be initiated and implemented at the state level, so that every woman receives medical treatment during pregnancy. We must continue to support Kansas women and their medical needs during pregnancy; however, giving the pregnancy of the woman the equivalent rights is not good or responsible health policy. HB 2761 is not the vehicle for furthering reliable prenatal care for women.

Thank you again for this opportunity to speak to the committee.

Sincerely,

Julie Burkhart
Executive Director

House Insurance
Date: 2/19/04
Attachment # 11

Planned Parenthood®
of Kansas and Mid-Missouri

Testimony by

Jennifer McAdam
Kansas Public Affairs Director/Lobbyist
Planned Parenthood of Kansas and Mid-Missouri

Before the Insurance Committee
of the
Kansas House of Representatives

On February 19, 2004

in Opposition to House Bill 2761

House Insurance
Date: 2/19/04
Attachment # 12

4401 W. 109th St., Suite 200 • Overland Park, KS 66211 • (913) 312-5100

My name is Jennifer McAdam. I am the Kansas Public Affairs Director and Lobbyist for Planned Parenthood of Kansas & Mid-Missouri. Thank you, Chair Barbieri-Lightner and members of this committee, for giving me the opportunity to discuss my concerns with HB 2761.

Planned Parenthood operates three health centers in Kansas, in Wichita, Hays, and Lawrence. We also operate eight centers in Missouri. In 2003, Planned Parenthood provided family planning and related care to over 30,000 women and men.

Planned Parenthood supports universal coverage for pregnant women and has worked to achieve this desperately needed goal. All pregnant women, regardless of their economic or immigration status, need access to early, risk-appropriate, and continuous pregnancy-related care in order to ensure the best possible outcomes for both mother and child.

HB 2761 is not true prenatal care.
This bill does not address prenatal care, in fact nowhere in this bill is the issue of prenatal care or health of the woman mentioned. The only change to current statute this bill makes is covering an "unborn child" from conception onward with HealthWave. This is not true prenatal care because the eligibility is conferred to the fetus, which could set up a conflict between the health of the woman and the health of the fetus, making the woman's health care secondary.

This also does not address the issue of postnatal care. Medicaid covers women with postnatal care for 60 days after giving birth. Sick women who recently delivered are less able to care for their babies. A lack of postpartum care harms mothers and their newborns. In this bill the woman would lose her health care when the child is born—since she was never covered to begin with.

HB 2761 compromises women's health.
By making the fetus and not the pregnant woman eligible for HealthWave, the proposed legislation would exclude from covered services care that may be critical to a pregnant woman's health, but which is not addressed directly to her developing fetus. For example, if a woman broke her leg during pregnancy, would this statute change permit coverage for treatment of that injury? While such treatment does not directly affect the fetus, it is certainly treatment that would indirectly benefit the fetus by improving the woman's health. Would a woman have coverage for dental care or treatment of back problems or any number of other problems caused or aggravated by her pregnancy that do not directly affect the fetus? What if she had a miscarriage? Would she be covered for the necessary care? Unlike the misguided approach of this bill, which covers only fetuses, a policy that provides pregnancy-related care for women avoids thee problems.

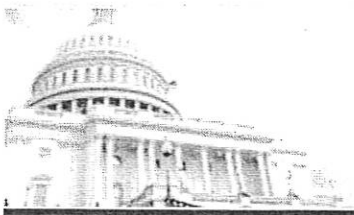
Alternatives to enacting this legislation:
1. Expand Medicaid coverage to 185% of the federal poverty line through a state plan amendment.
2. Expand Medicaid coverage to 200% of the federal poverty line through a waiver from Center for Medicare and Medicaid Services within the U. S. Department of Health and Human Services (similar to how Kansas currently has waivers for Home and Community Based Services).
3. Fund a program for immigrant women with state-only dollars.

Medicaid does a better job of protecting maternal and child health.
Under this proposed bill, the infant's care starts ticking in utero. If the infant begins coverage in the 9th week of pregnancy, the infant is dropped from coverage at three months of age. Under Medicaid, a newborn infant is guaranteed continuous eligibility for 12 months after birth.

I applaud the efforts to expand prenatal care to improve the lives of mothers and children, but this needs to be done in a way that does not compromise health care for political purposes. I urge you to oppose HB 2761.

12-2

March of Dimes
Saving babies, together



About Us

ISSUES & PRIORITIES

March of Dimes Comments on Proposed Rule to Redefine Child Under SCHIP

Honorable Thomas A. Scully
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-2127-P

May 6, 2002

Dear Mr. Administrator:

The March of Dimes is pleased to submit comments on a proposed rule published March 5, 2002 in the Federal Register that would revise the definition of child under the State Children's Health Insurance Program (SCHIP) to include children "from conception to birth through age 19." Specifically, the Notice of Proposed Rulemaking states: "In order to provide prenatal care and other health services, this proposed rule would revise the definition of 'child' under SCHIP to clarify that an unborn child may be considered a 'targeted low-income child' by the State and therefore eligible for SCHIP if other applicable State eligibility requirements are met. Under this definition, the State may elect to extend eligibility to unborn children for health benefits coverage, including prenatal care and delivery, consistent with SCHIP requirements."

In addition to this letter the March of Dimes would also like to associate itself with comments submitted by the American College of Obstetricians and Gynecologists and the Alan Guttmacher Institute as well as those submitted by the American Academy of Pediatrics.

Background
More than one in six women of childbearing age (15-44) – or 11 million women – were uninsured in 2000, according to data prepared for the March of Dimes by the U.S. Census Bureau. These women accounted for almost 30 percent of all uninsured Americans. More than half of these women (57 percent) had family incomes below 200 percent of poverty ($30,040 for a family of three in 2002).[i] Hispanic and Native American women in this age group were more than twice as likely as whites to be uninsured: 37 and 33 percent, respectively, compared with 17 percent. African-American and Asian women were also more likely than whites to be uninsured.[ii] Although more generous Medicaid eligibility for pregnant women has resulted in better rates of coverage for them than for women in general, there remains considerable room for improvement. In 1999, 13.4 percent of pregnant women (more than 420,000) were uninsured, an increase from 11 percent in 1990. [iii]

Prenatal care is fundamental to a healthy pregnancy resulting in a healthy baby. And as numerous studies have shown, lack of insurance can be a significant barrier to prenatal care.[iv] As is true for Americans in general, pregnant women's use of health services varies by insurance status. Uninsured pregnant women receive less care than those who are insured. According to the most recent data available, 18.1 percent of uninsured pregnant women in 1996 reported going without needed medical care during the year in which they gave birth.

12-3

This compares with 7.6 percent of privately insured pregnant women and 8.1 percent of pregnant women covered by Medicaid.[v]

In addition to improving access to health care for uninsured pregnant women, the March of Dimes supports elimination of any income eligibility disparities between mothers and newborns. By establishing a uniform threshold of eligibility for coverage, states could improve maternal health, eliminate waiting periods for infants and streamline the administration of publicly supported health programs. Currently, thirty-four states have income eligibility thresholds that are higher for infants than for mothers.[vi] Encouraging states to eliminate this disparity by allowing them to obtain the higher funding match rate available through SCHIP should be a policy priority for the U.S. Department of Health and Human Services.

The March of Dimes recognizes and appreciates the Administration's commitment to improving access to prenatal care for uninsured pregnant women. This goal is consistent with the mission of the Foundation, which is to improve the health of babies by preventing birth defects and infant mortality. Although the March of Dimes shares the Administration's goal of extending coverage to uninsured pregnant women, we respectfully disagree with the approach taken in the proposed regulation. Specifically, we believe coverage should be extended directly to the uninsured mother. As written, it is our view that the proposed rule does not meet the well-established, clinically-based standards of care for pregnancy developed and approved by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) and published in "Guidelines for Perinatal Care."[vii]

Standard of Care for Pregnancy Services

SCHIP should provide the standard of care recommended by AAP and ACOG for all income eligible pregnant women. These standards establish clinical mileposts for antepartum, intrapartum and postpartum care. Health professionals are expected to abide by these guidelines that are followed by both private plans and in publicly supported programs. In fact, Medicaid law and regulation offers a useful illustration of how public programs rely on these well-established standards [see Medicaid-covered pregnancy-related services under §1902(l) of the Social Security Act, as defined in §1902(a)(10)(G)(clause VII)]. Aside from SCHIP, we know of no other federally funded health program that denies coverage to pregnant women while providing coverage to their infants.

Many pregnant women require medical care that benefits both mother and fetus. Examples of such care include treatment for anemia, diabetes, hypertension, seizures and asthma. However, there are also specific medical needs of the mother that are distinct from those of the fetus. Such situations include breast masses, influenza (flu) vaccination and peptic ulcer disease. Under the proposed rule, it is not at all clear that the mother, while pregnant and during the period immediately following pregnancy, would be covered for the services required to treat these conditions and recommended by AAP and ACOG. In particular, the March of Dimes is concerned that postpartum treatment of hemorrhage, infection, episiotomy repair, and postpartum depression are not explicitly addressed in this proposed rule.

Alternative to NPRM

To ensure that pregnant women receive appropriate coverage that meets established medical standards of care, the March of Dimes recommends a statutory change to SCHIP. A legislative remedy that confers eligibility on the woman would permit states to provide the necessary scope of services recommended by AAP and ACOG. If this change in federal law were made and all states elected the option, studies done in 1999 and 2001 for the March of Dimes by Dr. Ken Thorpe demonstrate that up to 41,000 uninsured pregnant women could be covered.[viii] Several bills pending before Congress would allow states the flexibility to extend SCHIP coverage to pregnant women 19 and older.[ix] A statutory change would be permanent, has broad support, including the endorsement of the Administration, and the favorable federal matching rate would encourage states to amend their SCHIP programs to offer coverage that meets the established standards of medical care as outlined above.

Once again, thank you for your consideration of March of Dimes' concerns related to the proposed rule.
Sincerely,
Nancy S. Green, M.D.
Acting Medical Director

[i] *Thorpe, Ken. 2001. "The Distribution of Health Insurance Coverage Among Pregnant Women, 1999." A report prepared for the March of Dimes.*

[ii] *Bureau of Census, 2001. Unpublished data prepared for the March of Dimes.*

[iii] *Thorpe, 2001.*

12-4

iv Institute of Medicine. 1988. "Prenatal Care: Reaching Mothers, Reaching Infants." National Academy Press. Washington, DC.

v Bernstein, Amy. "Insurance Status and Use of Health Services by Pregnant Women." March of Dimes by the Alpha Center, December, 1999.

vi Center for Medicare and Medicaid Services. 2002. "The State Children's Health Insurance Program Annual Report, October 1, 2000 – September 30, 2001. February 6, 2002, and National Governors' Association. 2000. "Income Eligibility for Pregnant Women and Children." MCH Update.

vii American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. 1997. "Guidelines for Perinatal Care." Fourth edition.

viii Thorpe, 2001.

ix Current legislation pending before the Senate includes:

- *S. 724, the "Mothers and Newborns Health Insurance Act," co-authored by Senators Bond (R-MI) and Breaux (D-LA) and cosponsored by Senators Cochran (R-MS), Collins (R-ME), Daschle (D-SD), DeWine (R-OH), Dodd (D-CT), Landrieu (D-LA), Lieberman (D-CT), Lincoln (D-AR) and Lott (R-MS). This bill has been endorsemed by HHS Secretary Thompson on behalf of the Administration, the National Governors' Association, the National Conference of State Legislatures, and twenty-five national organizations.*
- *S. 1016, the "Start Healthy, Stay Healthy Act," co-authored by Senators Bingaman (D-NM) and Lugar (R-IN) and cosponsored by Senators Chafee (R-RI), Corzine (D-NJ), Lincoln (D-AR), Lugar (R-IN), and McCain (AZ).*
- *S. 1244, the "FamilyCare Act," co-authored by Senators Kennedy (D-MA) and Snowe (R-ME) and cosponsored by Senators Baucus (D-MT), Bingaman (D-NM), Breaux (D-LA), Chafee (R-RI), Clinton (D-NY), Collins (R-ME), Corzine (D-NJ), Daschle (D-SD), Edwards (D-NC), Graham (D-FL), Kerry (D-MA), Lincoln (D-AR), Rockefeller (D-WV), and Torricelli (D-NJ).*

Current legislation pending before the House of Representatives includes:

- *HR 2610, the "Mothers and Newborns Health Insurance Act," co-authored by Congresswoman Lowey (D-NY) and Congressman Hyde (R-IL) and 60 cosponsors.*
- *HR 2630, the "FamilyCare Act," authored by Congressman Dingell (D-MI) and 47 cosponsors.*
- *HR 3675, "Improved Maternal Health and Children's Health Coverage Act," authored by Congresswoman DeGette (D-CO) and 65 cosponsors.*
- *HR 3729, "Start Healthy, Stay Healthy Act of 2002," co-authored by Congressman Strickland (D-OH) and Congressman Ney (R-OH) and 33 cosponsors*

12-5

Insurance Committee,
Kansas House of Representatives

February 19, 2004

Testimony presented by Anna Holcombe, for the Kansas National Organization for Women (NOW)

P. O. Box 1061, Lawrence, KS 66044 Ph:785-550-9176

In opposition to HB 2761

Dear Chairperson Barbieri-Lightner and members of the committee,

Kansas National Organization for Women is a women's advocacy group. We have chapters throughout the state. We are your constituents.

Kansas NOW advocates for economic justice and to decrease domestic violence, as well as empower women within situations of domestic violence, so that they may leave their situation and better their lives. Kansas NOW also advocates for women's comprehensive health care and education. Women's prenatal care is an essential component of this aspect of our agenda.

However, Kansas NOW opposes HB 2761. We oppose the bill for two reasons.

A political agenda which serves to deprive women of their rights cannot paradoxically be used to provide women prenatal care. We feel that although this legislation would give prenatal care to women who do not qualify for Medicaid, **solving the problem of women's lack of prenatal care should not include ideological definitions of when life begins**. A fetus, from the moment of conception, is not considered a child among everyone. Discussion about this issue has been contentious. Often, such a point of contention has been used to deprive women of the right to safe, legal abortion, a right which ensures women of their health also.

The rights of a fetus can conflict with that of the woman in HB 2761. What does a woman who is undergoing cancer treatment do if she were to find that she is two weeks pregnant?

Moreover, why is a woman given health insurance during the duration of her pregnancy, and for three months given postnatal care, only to be left uninsured afterwards? What is to happen to a woman who has carried the pregnancy to term, only to find one year later that she suffers from an illness or injury whose treatment is costly? HB 2761 results in a serious financial burden on low income mothers and families. Lack of insurance for a mother does not support her ability to provide and care for her child. The interests of a child and mother are seen as separate in HB 2761. In reality, their basic health mutually benefits the other.

Kansas NOW strongly supports an alternative proposal that will truly address the problem of low income women's lack of access to prenatal care.

Solution: a Medicaid program which includes women whose income is up to 185% of the federal poverty guideline. This proposal would define woman's health as the ultimate goal of prenatal care. It will further women's postnatal care to that of 12 months, in contrast to the 3 months provided to her through HB 2761. A proposal such as this one will truly begin to offer children, women, and their families with the resources they need to maintain health. Such a proposal will not be a means of ideologically pursuing a particular political agenda that does not truly improve women's comprehensive healthcare and the health of children in Kansas.

States continue to have the authority to set eligibility requirements under their plan, including age limits. States are not required to extend coverage to this population. States which choose this option must submit a state plan amendment, subject to approval by the Secretary of U.S. Department of Health and Human Services.

Citizenship and immigration status requirements applicable to Medicaid also apply to SCHIP. Immigrants who are legally residing in the U.S. and meet the other Medicaid eligibility requirements are eligible for emergency care coverage. Those who legally resided in this country prior to August 22, 1996 are eligible for the full range of Medicaid services if a state chooses to cover them. Illegal immigrants are only eligible for emergency care. The Federal government is interpreting this revised definition of targeted low-income children to include unborn children of both legal and illegal immigrants. Presently illegal, and some legal immigrants, are not eligible for Medicaid and SCHIP, but the Federal government's position is that unborn children do not have status as aliens so they can receive benefits if the State chooses to exercise the option to cover unborn children.

SCHIP eligibility is limited by Federal statute to targeted low-income children and there must be a connection between the benefits provided and the health of the unborn child. Services for care after delivery, such as postpartum care, could not be covered as part of the SCHIP plan because they are not services for an eligible child unless the mother is eligible for SCHIP on her own.

The Federal rule provides for no new funding for this option. As a result each state must set its own priorities regarding the populations and services to be covered within this SCHIP allocation. States may choose not to exercise this option because they lack sufficient funds or for other reasons. This choice is left to each state. Kansas is projected to use up the Federal portion of its SCHIP funds by November 2007. Any expansion of the population covered would result in these funds being depleted sooner.

Based on the rate of pregnancies of the currently eligible SCHIP population, SRS estimates that at least 714 pregnancies a year will be included in the expanded coverage described in the bill. At the current rate of $5,700 per pregnancy, including the cost of delivery, the estimated cost of direct services for this bill is $4 million all funds ($1.1 million state general funds). In addition, SRS will incur some increased administrative costs to screen applications and determine eligibility. These costs are estimated to be $52,000 all funds ($14,000 state general funds).

SRS would respond to questions from the committee. Those questions may be submitted to Laura Howard, Deputy Secretary, SRS.