Approved: April 2, 2007
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 P.M. on March 8, 2007 in Room 526-S of the Capitol.

All members were present except:
Jeff Colyer- excused
Peggy Mast- excused

Committee staff present:
Jason Thompson, Revisor's Office
Renae Jefferies, Revisor's Office
Melissa Calderwood, Legislative Research
Mary Galligan, Legislative Research
Tatiana Lin, Legislative Research
Patti Magathan, Committee Assistant

Conferees appearing before the committee:
Representative Anthony Brown
Representative Mike Burgess
Beatrice Swoops KS Catholic Conference
Jean Gawdun KS For Life
Candy Shively, Social and Rehabilitative Services
April Holman, KS Action for Children
Paul D. Johnson, KS Catholic Conference
Jeff Cooper, KS Trial Lawyers Assoc
KS Coalition for Workplace Safety
John Ostrowski, AFLCIO
William Sneed, State Farm Insurance
David Hanson, KS Insurance Association

Others Attending:
See Attached List.

Chair Landwehr opened the floor for hearings on HB2266 - Umbilical cord donation information act.

Proponent, Representative **Anthony Brown** provided an overview of the bill which facilitates the donantion of umbilical cords for research. Benefits of having a dontation plan in Kansas include helping medical advances thru the recovery of stem cells for research, provides information for those wishing to donate and establishes procedures for disseminating this information. (Attachment 1)

Proponent, Representative **Mike Burgess** , called this a step in the right direction. He related that he and his wife had recently elected to provide a private donation on the birth of their daughter. He said that private donation can be expensive, but they looked on it as insurance for their newborn baby should problems arise. Another benefit is that it could possibly be used by other family members. There are only four receptors to match rather than 6 for normal transfusions. He explained that this bill should help soon-to-be parents better understand the uses of cord blood as well as their options to either have it donated to a public bank or collected and stored in a private bank for future use. (Attachment 2)

Proponent **Beatrice Swoops**, KS Catholic Conference, said that Congress funded a nationwide umbilical cord blood stem cell bank in 2003 because of the many clinical benefits being discovered from these cells. Umbilical cord blood can be used to treat more than 45 disorders such as genetic disorders or leukemia and certain cancers. Considered adult stem cell therapy, cord blood is richly endowed with a kind of stem cell that gives rise to oxygen carrying red blood cell. (Attachment 3)

Jean Gawdun, Kansans For Life (K.F.L.), said that K.F.L. supports **HB 2266**. This bill initiates a public health information program about umbilical cord blood. Cord blood is similar to bone marrow and has a better chance for match since only 3 or 4 of the 6 markers need to be matched. More than 70 diseases can be treated with cord blood. Advantages of using cord blood include that it is no risk to either mother or baby,

and poses fewer risks of certain complications to the recipient. (Attachment 4)

Written testimony provided by Concerned Women of America, proponent. (Attachment 5)

Dick Morrissey, Deputy Directory Health for Kansas Department of Health and Environment, provided neutral testimony, saying that there are 14 public banks in the United States and the closest is St Louis. There are 24 private banks. Physicians are advised to provide the following information to prospective parents: 1. Private cord blood banking should be discouraged for later personal use. It's main benefit is realized when there is knowledge of a full sibling in the family with a medical condition that could potentially benefit from cord blood transplantation. 2. Cord blood banking should be encouraged when it is stored in a bank for public use. If genetic or infectious diseases are identified in testing, the family will be notified. 3. Private storage of cord blood as biological insurance should be discouraged. Cord blood banks should comply with national accreditation standards, and, at a minimum, M.D.s involved in procurement of cord blood should be aware of collection, processing, and storage procedures. (Attachment 6)

Chair Landwehr closed hearings on **HB2266** - Umbilical cord donation information act and opened the floor to hear **HB2503** - Child support enforcement; insurance and workers comp payments; perfection of liens; unlawful acts.

Candy Shively, Kansas Department of Social and Rehabilitative Services (S.R.S.), testified as a proponent of **HB2503**, stating that this bill is important to S.R.S. It has two purposes. To increase the success rate by efficiently and effectively enforcing support orders when they go unpaid, and to streamline existing administrative enforcement procedures.

Current law provides an automatic lien on personal property for nonpayment of support. This bill sets out the procedure for attaching such a lien to two types of insurance proceeds. Projections are for this change to produce over one million annually for Kansas children when fully implemented. Approximately 75% goes back to families, with the remaining 25 percent being held to cover past due monies which were covered by SRS. S.R.S. plans to streamline existing administrative enforcement procedures. Ms. Shively introduced Jamie Corkhill, also of S.R.S., who was available for questions. (Attachment 7)

Proponent **April Holman**, KS Action for Children, said that Action for Children is a non-profit child advocacy organization focusing on health, early education, and family economic security. Family economic security is why they support this bill. (Attachment 8)

Paul D. Johnson, KS Catholic Conference, spoke as a proponent of **HB2503**. He said that 23 states currently have some form of child support collection procedures. (Attachment 9)

Jeff Cooper, opponent, representing the Coalition for Workplace Safety, is an attorney practicing law in Kansas who also teaches workers compensation classes at Washburn University. The Coaltion fully agrees that children should be protected and supported, however they do not support **HB2503**.

Current workers compensation law provides a mechanism to collect unpaid child support from injured workers. Kansas workers compensation benefits are among the lowest in the Nation. **HB2503** would make this bleak scenario even worse by adding the requirement for every insurance company or group funded pool to determine if a child support exists within 60 days, notify the Secretary of Social and Rehabilitation Services by complying with procedures (which are not defined in statute) and then wait another 15 days before making any payment. The law would required every insurer to wait 60 days, and possibly over 75 days, before paying any benefits.

This bill has potential for unforseen consequences, such as an injured worker who has to go 60 days without a paycheck. Most working people would have difficulty paying the ordinary expenses of daily living.

Questionable sections of the bill include Sec. 2(c), (Page 2, Line 8) where no limitation is provided in regard to the amount that can be attached. Section 2(d) also appears to be in direct conflict with K.S.A. 44-514. Page 3, Lines 35-39 allows an insurance company to make a payment to be granted immunity

without verification that payment is appropriate and payable.

Major portions of **HB 2503** would radically and unnecessarily change the existing law and would impose further obligations on employers and insurance carriers, resulting in long delays in injured workers receiving benefits. Current law is a clear and manageable mechanism for payment of current and past due child support from workers compensation benefits. (Attachment 10)

John Ostrowski, Kansas AFLCIO said that though it is universally agreed that enforcement of child support orders is important and worthwhile state policy, the Kansas AFL-CIO must oppose **HB 2503** in its present form as it relates to workers compensation. The bill presents mechanical problems, will raise workers compensation premiums, and essentially "kills the fly with a sledgehammer."

Key points of the bill are: a mechanism already exists to collect child support, every claim will be substantially delayed, premiums will increase for Kansas employers, the bill conflicts with existing law for timely payments, medical liens appear to be affected by this bill, and work injuries often create an arrearage. (Attachment 11)

William Sneed, Legislative Counsel for State Farm Insurance, testified in opposition to **HB 2503**. The obligations of checking for liens places an untenable requirement on insurers. One significant concern with this bill is compliance. The burden is on our claims employees to "adhere" to the outlined standard of the bill thereby making the claim process more cumbersome. Absent sophisticated automation, accurate compliance will be virtually impossible. (Attachment 12)

David Hanson, KS Insurance Association, testified from a neutral position. They are in support of the efforts to collect child support, however they share the concerns raised here by the opposition. They understand the intent is to only involve workers' compensation and personal injury insurance payments, but the terminology in the bill may need some clarification to achieve that purpose. Other concerns, are electronic data exchanges and confidentiality of data, and the burden this bill will place on individual companies. (Attachment 13)

We would urge further study and discussion to determine the possible ramifications of such legislation and the potential problems we may face.

Chair Landwehr closed Hearings on **HB 2503** and appointed a sub-committee to address questions and conflicts raised today. Those appointed to the sub-committee were: Representatives Joe Patton (Chair), Mark Rhoades, David Crum, Jim Ward, and Annie Tietze.

Meeting was adjourned at 3:18 P.M. Next meeting will be March 12 at 1:30 P.M.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE GUEST LIST

DATE: March 8, 2007

NAME	REPRESENTING
Dick Morrissey	KDHE
[illegible]	KDHE
Lindsey Douglas	Hein Law Firm
Jamie Corkhill	SRS
Candy Shively	SRS
April Holman	Kansas Action for Children
[illegible]	" "
Suzanne Wikle	"
Sarah Tidwell	Ks State Nurses Assn
Judi Tremaine	CWA
Judy Smith	CWAofKS
Kris Trimmer	KNEA
Paul Johnson	Ks. Catholic Conf.
Beatrice Swoopes	Kansas Cath. Conf.
Mike Burgess	51st House Dist.
Susan Kang	KDHE
[illegible]	[illegible] & Associates

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS

VICE CHAIR: FINANCIAL INSTITUTIONS
MEMBER: FEDERAL AND STATE AFFAIRS
TAXATION

HB 2266

I. Introduction
- A. Overview of the bill
- B. Why HB 2266
- C. What does the bill does

II. Why HB 2266
- A. Answers the Question How can I donate umbilical cord for research
- B. Medical Advances
- C. Can recover Adult Stem cells
- D. Non-Controversial practice
- E. Already demand for uses
  - 1. Breast Cancer Research

III. What are the implications of HB 2266
- A. KDHE would provide information to Care Providers
- B. Care Providers would give this information to pregnant women
- C. Outlines some information to be included in the piece
- D. Fiscal note of $48,000
  - 1. $40,000 for information piece
  - 2. $8,000 for mail costs
- E. No penalties for either physicians or KDHE for non-compliance
- F. Simply and effort to educate pregnant women about donation

IV. Conclusion
- A. Umbilical Cord donation can help in medical advances
- B. Provides information for those wishing to donate
- C. Establishes procedure for disseminating this information

House Health and Human Services
DATE: 3-8-07
ATTACHMENT 1

STATE OF KANSAS
HOUSE OF REPRESENTATIVES

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MIKE BURGESS

Testimony in Support of HB2266

March 8, 2007

Chairman Landwehr and members of the House Health & Human Services Committee:

As most of you may know, I recently became a dad. My wife and I after researching cord blood banking, decided to utilize the services of a private cord blood bank. It was fairly expensive, but we viewed it as an insurance policy for Meredith Grace.

A number of our friends have had children in the last couple of years. To my knowledge, we are the only ones who took advantage of one of these umbilical cord blood banking services. In a vast, vast majority of births here in Kansas, the umbilical cord blood is just thrown away, and that is a travesty.

To date, umbilical cord blood has been used in more than 6,000 transplants for children and adults. In many cases, the cord blood was used by the baby's sibling. Other transplants have occurred for the newborn herself, the newborn's mother, father, and the newborn's cousin.

In the past two years alone, research has demonstrated that cord blood stem cells can differentiate into other types of cells in the body. The regenerative qualities of stem cells have been brought to the forefront in the field of cellular repair. Stem cells have been labeled an important biological resource and researchers are conducting more and more studies to unlock the potential of umbilical cord blood stem cells in future applications for diseases like Alzheimer's, diabetes, heart and liver disease, muscular dystrophy, Parkinson's disease, spinal cord injury, and stroke.

With cord blood, the immune cells are less mature than those in bone marrow, and therefore siblings are twice as likely to be able to use each other's cord blood, compared to bone marrow.

In most cases here in Kansas, the parents and grandparents are not aware of the options when it comes to the umbilical cord blood. This bill should help the soon-to-be parents to better understand the uses of cord blood as well as their options to either have it donated to a public bank or collected and stored in a private bank for future use. For that reason, I urge you to pass HB266 and recommend it favorable for passage.

ouse Health & Human Services
526-S, 1:30 p.m.
March 8, 2007

6301 ANTIOCH • MERRIAM, KANSAS 66202 • PHONE/FAX 913-722-6633 • WWW.KSCATHCONF.ORG

TESTIMONY ON H.B. 2266
Umbilical Cord Donation Information Act

Madame Chair and members of the Committee:

My name is Beatrice Swoopes; I am the Associate Director of the Kansas Catholic Conference the public policy office for the Catholic Church in Kansas. Thank you for the opportunity to speak in favor of H.B. 2266, the Umbilical Cord Donation Information Act.

In 2003 Congress approved funds to help create a nationwide umbilical cord blood stem cell bank, because of the many clinical benefits being discovered from these cells which in the past were usually discarded after birth. Umbilical cord blood can be used to treat various genetic disorders that affect the blood and immune system, leukemia and certain cancers, and some inherited disorders. To date, more than 45 disorders can be treated with stem cells from umbilical cord blood.

According to a report in **National Geographic** (July 2005) cord blood transplants, considered an adult stem cell therapy because the cells come from infants, not embryos, have been performed since 1988. Like bone marrow, which doctors have been transplanting since 1968, cord blood is richly endowed with a kind of stem cell that gives rise to oxygen-carrying red blood cells, disease-fighting white blood cells, and other parts of the blood and immune systems. The report also stated that "the stem cells found in bone marrow and cord blood can burrow into a person's bones settle there for good, and generate fresh blood and immune cells for a lifetime."

There are adult stem cells throughout the human body (mouth, nose, the pulp of baby teeth, fat tissue); and adult stem cells obtained from umbilical cord blood and placentas. Archbishop Joseph Naumann of the Archdiocese of Kansas City in Kansas, and Chairman of the Kansas Catholic Conference Board stated in a recent article in the **LEAVEN** (the local Archdiocesan Newspaper): "The Catholic Church enthusiastically supports research using adult stem cells because they can be harvested without doing any harm to the donor.

MOST REVEREND RONALD M. GILMORE, S.T.L., D.D.
DIOCESE OF DODGE CITY

MOST REVEREND JOSEPH F. NAUMANN, D.D.
Chairman of Board
ARCHDIOCESE OF KANSAS CITY IN KANSAS

MOST REVEREND PAUL S. COAKLEY, S.T.L., D.D.
DIOCESE OF SALINA

MOST REVEREND MICHAEL O. JACKELS, S.T.D.
DIOCESE OF WICHITA

MICHAEL P. FARMER
Executive Director

MOST REVEREND EUGENE J. GERBER, S.T.L., D.D.
BISHOP EMERITUS - DIOCESE OF WICHITA

MOST REVEREND GEORGE K. FITZSIMONS, D.D.
BISHOP EMERITUS - DIOCESE OF SALINA

Studies suggest that stem cells from cord blood offer some important advantages over those retrieved from bone marrow. Cord blood stem cells are much easier to get because they are readily obtained from the placenta at the time of delivery. Also a broader range of recipients may benefit from cord blood stem cells. They can be stored and transplanted back in the donor, to a family member or to an unrelated recipient.

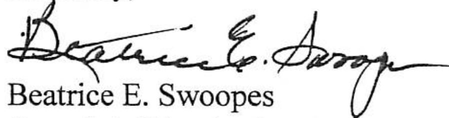
Expectant parents can make arrangements before the birth of their child to have their baby's cord blood collected immediately after birth, and stored by a commercial blood bank for their own use. They can also donate to a public bank to be available to any appropriately matched individual needing a transplant. If parents use a commercial bank, the initial cost ranges from $250 to $1,500, plus an annual storage fee of $50 to $100. Some health insurance companies are beginning to cover these costs.

Families who want to donate their baby's cord blood to a public bank for use by others should be fully informed of their responsibilities and other implications of their donations.

H.B. 2266 would allow for that type of information. With the number of therapies being produced already with cord blood stem cells and the bright future for many more, parents should be given the opportunity to make a fully informed decision to benefit themselves or others by their donations.

H.B. 2266 is a "win-win" proposal for all involved. We urge your support of this bill.

Sincerely,



Beatrice E. Swoopes
Associate Director

Note – The March of Dimes "Quick Reference and Fact Sheet" was also a source for this testimony.

www.kfl.org

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Testimony in support of HB 2266
Umbilical Cord Donation Information Act
House Health & Human Services Committee
March 8, 2007

Dear Chairwoman Landwehr and Members of the Committee,

My name is Jeanne Gawdun and I am the senior lobbyist for Kansans for Life. KFL supports HB 2266, the Umbilical Cord Donation Information Act.

HB 2266 initiates a public health information program about umbilical cord blood. What is cord blood? After a baby is born and the umbilical cord is cut, some blood remains in the blood vessels attached to the placenta as well as in the part of the umbilical cord that remains. After birth, the baby no longer needs this extra blood. This blood is called placental blood or umbilical cord blood, “cord blood” for short. (see Attachment A)

Cord blood contains all of the normal elements of blood-red blood cells, white blood cells, platelets and plasma. But it is also rich in hematopoietic (blood-forming) stem cells, similar to those found in bone marrow. This is why cord blood can be used for transplantation instead of bone marrow, and it is increasingly being used as such an alternative.

Most cord blood transplants have been used to treat diseases of the blood and immune system. Cord blood has also been used to restore the functional deficiencies of several genetic metabolic diseases. To date, more than 70 different diseases have been treated with cord blood transplants.

What are the advantages of cord blood?

1. Cord blood collection is easy and poses no risk to mother or baby.
2. Cord blood is collected in advance, tested and stored frozen, ready to use.
3. Cord blood doesn’t require a perfect match. As a result, a national inventory of only 150,000 ethnically diverse cord blood stem cell units will provide 80% of U.S. citizens with a suitable match.
4. Cord blood poses fewer risks of certain complications to the recipient. The immune cells in cord blood seem to be less likely than those in bone marrow from unrelated donors to attack the patient’s own tissues (graft vs. host disease). Cord blood is also less likely to transmit certain viruses.

(see Attachments B, C and D for further information on the above)

On December 20, 2005, President Bush signed into law H.R. 2520, the "Stem Cell Therapeutic and Research Act of 2005," which created a new Federal program to collect and store cord blood, and expanded the current bone marrow registry program to also include cord blood. At this time, there is no cord blood bank in Kansas, and we support efforts to attract such banks to the state and educate the public as to the importance of cord blood banking. While HB 2266 is a positive first step, Attachment F shows the language of a current Senate proposal in Oklahoma which we believe is a good direction for Kansas to follow.

Thank you for your consideration. I stand for questions.

Kansas Affiliate of the National Right to Life Committ-

House Health and Human Services
DATE: 3-8-07
ATTACHMENT 4-1

CORD BLOOD (from Wikipedia, the free encyclopedia online)

Umbilical cord blood is human blood from the placenta and umbilical cord that is rich in hematopoietic stem cells. Cord blood is collected after the umbilical cord has been detached from the newborn, and utilized as a source of stem cells for transplantation. Cord blood, once seen as waste to be discarded after a birth, is now viewed as a precious resource. Since the first successful cord blood transplant was performed on a child with Fanconi's anemia in 1988, over 3,500 patients have been treated with this procedure[1], including 14 who used their own blood cells.

Cord blood stem cells are more proliferative and have a higher chance of matching family members than stem cells from bone marrow. Fathers have a 25% chance of matching their child's cord blood stem cells. Siblings have a 25% chance of being a perfect cord blood match. According to research in the Journal of Pediatric Hematology/Oncology (1997, 19:3, 183-187), the odds that a child will need to use his or her own stem cells by age twenty-one for current treatments are about 1:2,700, and the odds that a family member would need to use those cells are about 1:1,400.

CORD BLOOD BANKS

Cord blood is stored by both public and private cord blood banks. Public cord blood banks store cord blood for the benefit of the general public, and most U.S. banks coordinate matching cord blood to patients through the National Marrow Donor Program (NMDP). **Public cord blood banking is strongly supported by the medical community**.

Private cord blood banks are for-profit organizations that store cord blood for the exclusive use of the donor or donor's relatives. The cost of private cord blood banking is approximately $2000 for collection and approximately $125 per year for storage as of 2006. The donation of cord blood may not be available in all areas, however the opportunity to donate is becoming more available. Several local cord blood banks across the United States are now accepting donations from within their own states. The cord blood bank will not charge the donor for the donation, but the OB/GYN may still charge a collection fee of $100-$250, which is usually not covered by insurance. However, many OB/GYNs choose to donate their time.

COLLECTION

When a mother chooses to donate cord blood (which is rich in blood stem cells) or store it for private use, the initial collection process is the same and poses no danger to mother or baby if done properly (see below for discussion of medical issues).

There are two methods to collection, in-utero and ex-utero. During in-utero collection, the cord blood is collected while the doctor or midwife is waiting for the placenta to deliver naturally. There is a period of 5-10 minutes after the baby is delivered and before the placenta is delivered where there is ample time to collect the cord blood. During an ex-utero collection, the placenta is delivered and then placed in a sterile supporting structure with the umbilical cord hanging through the support. The cord blood is collected by gravity drainage yielding between 40-150 mL.

After collection the cord blood units must be immediately shipped to a cord blood bank facility. At public cord blood banks, this blood is then analyzed for infectious agents and the tissue-type is determined. Cord blood is processed and depleted of red blood cells before being stored in liquid nitrogen for later use.

There are many ways to process a cord blood unit and there are differing opinions on what is the best way. Some processing methods separate out the red blood cells and remove them while others keep the red blood cells. However, the unit is processed, a cryopreservant is added to the cord blood to allow the cells to survive the cyrogenic process. After the unit is slowly cooled to -90 Celsius it can then be added to a liquid nitrogen tank that will keep the cord blood unit frozen at -196 Celsius.

DISEASES TREATABLE using BONE MARROW or CORD BLOOD

from http://www.marrow.org/PATIENT/Undrstnd_Disease_Treat/Lrn_about_Disease/index.html

The diseases listed below are those that may be treated by a bone marrow or cord blood transplant. The list includes diagnoses for which transplant is a standard treatment as well as diagnoses for which the role of transplant is a newer option.

Leukemias and lymphomas, including:

- Acute myelogenous leukemia
- Acute lymphoblastic leukemia
- Chronic myelogenous leukemia
- Chronic lymphocytic leukemia
- Juvenile myelomonocytic leukemia
- Hodgkin's lymphoma
- Non-Hodgkin's lymphoma

Multiple myeloma and other plasma cell disorders

Severe aplastic anemia and other marrow failure states, including:

- Severe aplastic anemia
- Fanconi anemia
- Paroxysmal nocturnal hemoglobinuria (PNH)
- Pure red cell aplasia
- Amegakaryocytosis / congenital thrombocytopenia

SCID and other inherited immune system disorders, including:

- Severe combined immunodeficiency (SCID, all sub-types)
- Wiskott-Aldrich syndrome

Hemoglobinopathies, including:

- Beta thalassemia major
- Sickle cell disease

Hurler's syndrome and other inherited metabolic disorders, including:

- Hurler's syndrome (MPS-IH)
- Adrenoleukodystrophy
- Metachromatic leukodystrophy

Myelodysplastic and myeloproliferative disorders, including:

- Refractory anemia (all types)
- Chronic myelomonocytic leukemia
- Agnogenic myeloid metaplasia (myelofibrosis)

Familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders

Other malignancies, Childhood Cancers

National Geographic News April 6, 2006

Umbilical Cord Blood: The Future of Stem Cell Research?

Researchers at the University of Minnesota recently announced that they were able to largely **reverse the effects of stroke** in lab rats **using stem cells found in human umbilical cord blood.** In the experiment, conducted by neurologist Walter Low and his colleagues, the transplanted stem cells took on properties of brain cells and seemed to spur the rats' brains to "rewire" themselves. The researchers almost **fully healed** the rats 48 hours after the animals sustained brain damage. Typically doctors need to act within three hours to treat a human stroke patient successfully.

Cord-blood cell transplants are already becoming common as a therapy for diseases of the blood. Now scientists like Low are finding that stem cells from umbilical cord blood—once thought capable only of turning into blood cells—**may be able to grow into other kinds of cells** as well. Such advances are casting cord blood, previously regarded as medical waste left after childbirth, in a new light.

The Center for Cord Blood in Minneapolis, Minnesota, the largest public donor bank in the United States, reports that the likelihood of finding a perfect match in its bank has doubled in the last four years. The center's website states that more than 95% of patients searching its registry are able to find suitable matches today.

It's not clear yet whether the therapy Low's team used on rats will ever be safe or effective in humans. But many people with other life-threatening conditions have been healed with this easily collected source of stem cells. **Today doctors use cord blood cells to treat about 70 diseases,** mostly anemias or cancers of the blood, such as leukemias and lymphomas. Patients with immune-system diseases—like Severe Combined Immunodeficiency, commonly called the Boy in the Bubble Disease—have also responded to cord blood treatment. "[Cord blood stem cells] can be used to replace failed blood cells," explained Kristine Gebbie, a professor of nursing at Columbia University in New York.

6.000 patients worldwide have been treated with cord blood stem cell transplants to date, though the U.S. Food and Drug Administration still considers the procedure experimental. For the therapies, doctors typically obtain cord blood from the placentas of volunteer donors after they give birth. The **blood is then banked** with one of several public registries. If the donor and patient aren't genetically similar enough, the patient's body will reject the transfusion. The result can be fatal. "A war goes on [between donor and recipient cells], and you want the donor [cells] to win," said Mary Laughlin, an expert in cord blood transplantation on the faculty at Case Western Reserve University in Cleveland, Ohio.

But **cord blood transplants are more forgiving** than other procedures, like bone marrow transplants, if the donor isn't a perfect genetic match. And as volunteer donor banks grow, patients are often able to find suitable cord blood donor matches months before they might identify an appropriate bone marrow donor. The Center for Cord Blood in Minneapolis, Minnesota, the largest public donor bank in the United States, reports that the likelihood of **finding a perfect match in its bank has doubled** in the last four years. The center's Web site states that more than **95 % of patients** searching its registry are able **to find suitable matches** today.

In 2004 the U.S. federal government set aside money to establish a central system for cord blood banking, to be facilitated by the Department of Health and Human Services. Last year President George W. Bush signed into law the Stem Cell Therapeutic and Research Act, which supports **building a reserve of 150,000 cord blood units from ethnically diverse donors.** Gebbie is optimistic that an effective national system will be in place soon. The biggest challenge, she says, is getting more units from minority groups. Because of limited donor pools, minorities have had difficulty finding suitable matches.

Medical Hope in Umbilical Cord Blood

Healing Powers May Provide Cures for Many Deadly Maladies

October 23, 2005 By Ronald Kotulak, Science Reporter Chicago Tribune

When 5-year-old Gina Rugari started kindergarten in Cincinnati this fall she brought her own crayons, pencils, glue sticks and pink backpack, but the **blood flowing through her arteries was not her own.** Her red and white cells are the result of an **umbilical cord blood transplant** she had **at 3 weeks** of age.

The transplant from an unrelated donor repopulated her bone marrow with stem cells, the wellspring of her new blood supply. Her blood does all the things blood is supposed to do, but in Gina's case it does something much more: It prevents the swift destruction of her brain by a faulty gene she was born with.

What is proving to be a lifesaver for Gina is also turning out to be a medical treasure trove for scientists. **Cord blood is surprising researchers with previously unrecognized healing powers** that go far beyond its known effectiveness against childhood leukemia and some other disorders.

Yet despite growing efforts to encourage parents to donate cord blood to banks that freeze and store it for possible future use for their child, or for other patients in need, most of the blood is still discarded after birth.

Gina's condition, a **rare genetic defect called Krabbe disease,** is the latest entry on the list of illnesses for which cord blood is effective. Others range from **leukemia and sickle cell disease to aplastic anemia and immunodeficiency diseases.** Early research in animals suggests that cord blood may provide a new bounty of cures and treatments for many other medical conditions, including heart attack, Parkinson's disease, stroke, Alzheimer's disease, muscular dystrophy, diabetes, spinal cord injury and amyotrophic lateral sclerosis.

"This is all new biology, which could have an unlimited potential," said Dr. Paul Sanberg, director of the University of Southern Florida's center for aging and brain repair. "Cord blood research is moving us into an era of regenerative medicine where we're going to be approaching chronic degenerative diseases with ways to repair them by generating new tissues."

All of this was unanticipated in 1990 when the University of Minnesota's Dr. John Wagner performed the first cord blood transplant, a risky procedure then that everyone said wouldn't work. His boss told him to stop the research, saying it would never be of any use. "Now we're seeing that it's a potentially untapped resource," said Wagner, who plans to start clinical trials next year using cord blood to treat autoimmune diseases. "What we have seen so far may be only a drop in the bucket." ...

Cord blood does not have to be perfectly matched, because the immaturity of a newborn's immune system means the white blood cells are **less likely to attack the transplant recipient**. To treat children with a life-threatening genetic defect, their own bone marrow is chemically destroyed to make room for blood-making donor stem cells. The donor cells home in on the patient's marrow, where they produce a healthy new supply of blood that contains the vital enzymes the children lack.

The stem cells also migrate to the brain and other areas of the body, where they take up residence to supply damaged cells with the enzymes and proteins they need to build myelin, snuff out inflammation, battle infection, spur growth and in other ways restore and maintain the health of cells.

Why is cord blood important for ethnic minorities?

Many patients who need a bone marrow transplant cannot find a suitable donor - no relative that matches and no match among volunteer bone marrow donors. There are differences in the frequency of certain blood antigen (HLA) types among ethnic groups. Therefore, patients are more likely to find a good match among donors from their own ethnic group. **African-American patients who need bone marrow transplantation have an especially hard time finding an unrelated bone marrow donor.** There are three reasons for this difficulty. The first is simply numerical. African-Americans make up only 12% of the U.S. population and, thus, fewer potential donors are available. The second reason is that there is much greater variation in HLA-types among people with African ancestry than in any other group. And third, some people who have both African and European or other ancestry have combinations of the HLA types that are unique.

2002 US Government Accounting Office Report: Estimates for Bone Marrow Transplantation (1997-2000)

Ethnic Group	Percent of Patients Seeking a Bone Marrow Donor	Percent of Donor Volunteers* Registered in NMDP	Percent of Patients Receiving Bone Transplant Facilitated by NMDP
Asian	3.7%	8%	2.4%
African-American	12.1%	10%	6.3%
Hispanic	12.5%	11%	7.8%
Caucasian	69.1%	67%	61.9%

*Donor ethnicity known.

2002 GAO Report
(National Marrow Donor Program May Be Underutilized)
"... equal access to a transplant may not be attainable."

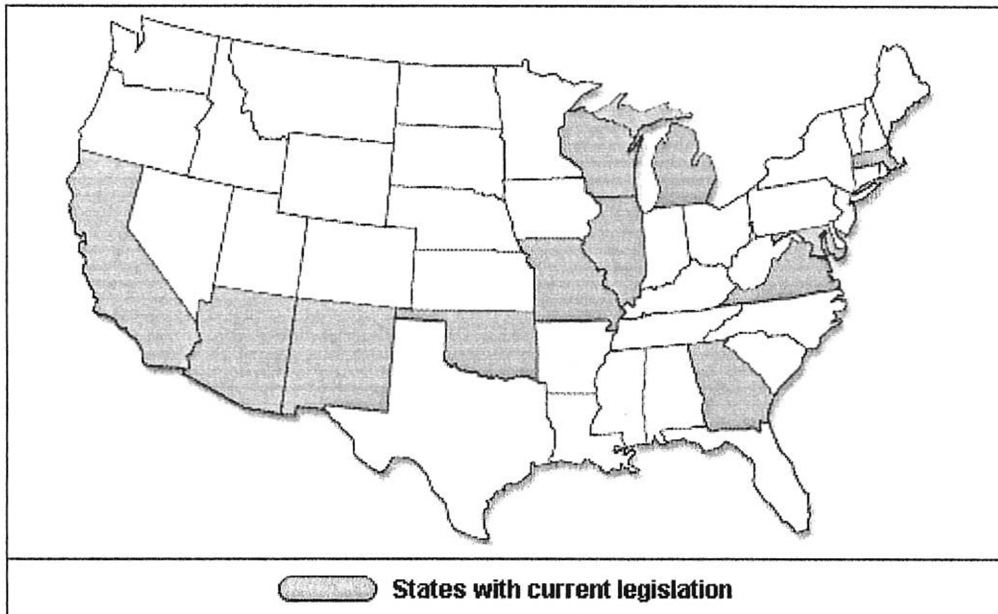
It is estimated that at least three times as many African-American volunteer bone marrow donors than Caucasian donors would be needed for African-American patients to have a chance that equals that of Caucasian patients to find a match among bone marrow donor registries. As a result, African-American patients are much less likely to find a matched, unrelated bone marrow donor. **With cord blood, however, a partial match is acceptable and most African-American patients can find a suitable cord blood unit.** Large public cord blood bank inventories, therefore, can make up for the difficulty in finding suitable bone marrow donors for minority patients.

African-Americans, like everyone else, need transplants for leukemia, lymphoma, and inherited diseases such as severe combined immune deficiency (SCID or "boy-in-the-bubble" syndrome). In addition, African-Americans are more likely than others to suffer from sickle cell disease, a sometimes devastating and crippling disease that eventually will be lethal for most patients. At present, the only cure is a transplant. Patients from other ethnic minority groups also have more difficulty finding a matching unrelated bone marrow donor. Again the problem is numerical. Minority groups simply have smaller numbers from which to draw potential donors. Many Hispanic patients also have ancestry from more than one ethnic group. People from different regions of Asia also tend to differ in their HLA types.

The first patient to receive a cord blood transplant from an unrelated donor for sickle cell disease was Keone Penn (pictured here with his mother, Leslie). Born with severe sickle cell anemia (a disease that afflicts more than 70,000 Americans and a disproportionate number of African-Americans), Keone Penn suffered a stroke at age five and endured frequent episodes of pain throughout his childhood. He received regular blood transfusions through a chest catheter for his anemia, Keone continued to have pain crises, bone and joint crises and developed kidney complications. On December 11, 1998, Keone got cord blood from a healthy donor to the New York Blood Center's National Cord Blood Program. His recovery was long and, at times, extremely difficult. Eventually, these complications subsided. Keone's new stem cells now produce normal red blood cells with normal hemoglobin. The swelling in his joints has subsided and Keone has not had one further pain crisis. On the one-year anniversary of his transplant, Keone's doctor pronounced him cured

CORD BLOOD AWARENESS.ORG
Educating America about Cord Blood Banking

Cord Blood Legislation: State by State
Each year more than 35,000 American children and adults with life threatening illnesses find themselves in need of a stem cell transplant. The growing need for a suitable stem cell match has garnered the attention of state lawmakers. In response to their constituents, state legislators across the country are introducing legislation intended to help physicians and expectant parents on the options for donating or banking lifesaving newborn stem cells.



Arizona
Beginning in January 2007, health care professionals will be required to inform a pregnant patient about her ability to family bank or donate her newborn's cord blood. The Umbilical Cord Blood; Donation; Information Act will advise expectant mothers about the benefits of umbilical cord blood collection to the newborn and immediate biological family. Arizona is the first state to inform expectant parents about free cord blood collection and storage programs offered by family and sibling donor banks.

California
Consistent with the recommendations of the Institute of Medicine (IOM) the Maternal and Child Health Advancement Act will authorize the Department of Health to create a cord blood awareness campaign that will offer standardized, objective information to expectant mothers about the differences between public and private banking, current and future uses of cord blood, and how medical or family history can impact a family's decision to donate or family bank their newborn's stem cells.

Georgia
The Governor issued an executive order to establish the Delivering the Cure: Newborn Umbilical Cord Blood Initiative Act to establish a commission whose task will include promoting awareness and encouraging donation of postnatal tissue and fluid to public or private difference between public and private banking programs; the medical process involved in the collection and storage of postnatal tissue and fluid; the current and potential future medical uses of stored postnatal tissue and fluid; the benefits and risks involved in the banking of postnatal tissue and fluid; and the availability and cost of storing postnatal tissue and fluid in public and private umbilical cord blood banks.

Illinois
In 2004, the Hospital Licensing Act was amended to add a mandate that hospitals offer pregnant women the option to donate their newborn's cord blood to a public bank.

Maryland
The Maryland Department of Health and Mental Hygiene - Umbilical Cord Blood Donation - Educational Materials Act would require the Department of Health to develop educational materials about cord blood donation and would require specified obstetricians and hospitals to distribute specified educational materials to specified patients; etc.

Massachusetts
An Act Enhancing Regenerative Medicine in the MA Commonwealth has become law and has been incorporated into the Acts that govern the state. The Massachusetts Department of Public Health will establish a program to educate women on public and private cord blood banking options and their differences. Hospitals within the commonwealth will inform pregnant patients of their ability to donate to a public bank.

Michigan
Several bills focused on creating a network of umbilical cord blood banks were recently passed. An additional bill was passed to promote public awareness and provide information that explains the differences between public and private banking and educate expectant mothers about all available cord blood options.

Missouri
Currently unfunded the Establishes the Criteria for Grants to Umbilical Cord Blood Banks Act will expand existing cord blood banks and establish new ones in the sate of Missouri.

New Mexico
Umbilical Cord Blood Banking Act requires physicians to inform patients about cord blood donation and requires the Department of Health to prepare and distribute written publications informing expectant mothers about cord blood donation.

Oklahoma
The Danielle Martinez Act, named for a 7-year-old leukemia patient establishes an advisory council to develop recommendations for a cord blood donor program.

Virginia
The Virginia Cord Blood Initiative Act establishes the Virginia Cord Blood Bank Initiative as a public resource for treating patients with life threatening illnesses and for use in advancing basic and clinical research. Women will be offered the opportunity to donate cord blood. The initiative will do research and outreach particularly for ethnic and racial minorities. Information will be disseminated through health departments and Medicaid.

Wisconsin
The Donation of Umbilical Cord Blood Act requires the principal prenatal healthcare provider of a pregnant woman to offer her information prior to the 35th week of pregnancy about her option to donate umbilical cord blood.

Current Cord Blood Bank & Public Education Proposal
STATE OF OKLAHOMA
1st Session of the 51st Legislature (2007)

SENATE BILL 139 By: Gumm

AS INTRODUCED
An Act relating to public health and safety; directing the University of Oklahoma Health Sciences Center in collaboration with the Commissioner of Health to establish and maintain a public umbilical cord bank; directing the State Department of Health to establish a program to educate maternity patients; requiring certain physicians and hospitals to provide specified information; clarifying obligation of hospital; clarifying right of maternity patients; clarifying religious rights; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2175 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. On or before January 1, 2008, the University of Oklahoma Health Sciences Center, in collaboration with the Commissioner of Health, shall establish, operate and maintain a public umbilical cord bank for the purpose of collecting and storing umbilical cord and placental tissue donated by maternity patients at hospitals licensed in this state.

B. On or before January 1, 2008, the State Department of Health shall establish a program to educate maternity patients with respect to the subject of cord banking. Such program shall provide maternity patients with sufficient information to make an informed decision on whether or not to participate in a private or public umbilical cord blood banking program and shall include, but not be limited to explanations and information on:
1. The difference between public and private umbilical cord banking;
2. The medical process involved in umbilical cord banking;
3. The current and potential future medical uses of stored umbilical cord;
4. The benefits and risks involved in banking umbilical cord ; and
5. The availability and cost of storing umbilical cord and placental tissue in public and private umbilical cord banks.

C. 1. Each physician licensed in this state and each hospital licensed in this state shall inform each pregnant patient under the physician's or hospital's care, not later than thirty (30) days from the commencement of the patient=92s third trimester of pregnancy, of the opportunity to donate to the public umbilical cord bank, established under subsection A of this section, and tissue extracted from the umbilical cord and placenta, following delivery of a newborn child, at no cost to the patient.
2. Nothing in this section shall be construed to:
a. obligate a hospital to collect umbilical cord or placental tissue if, in the professional judgment of a physician licensed in this state, the collection would threaten the health of the mother or child,
b. prohibit a maternity patient from donating or storing extracted from the umbilical cord or placenta of the patient's newborn child to a private umbilical cord and placental tissue bank, or
c. impose a requirement upon attending medical personnel who object to umbilical cord or placental tissue donation as being in conflict with their religious tenets and practice.

SECTION 2. This act shall become effective November 1, 2007.

51-1-1445

Testimony in Support of HB 2266
House Health and Human Services Committee

March 8, 2007

Chairperson Landwehr and Members of the Committee:

Concerned Women for America of Kansas is in support of HB 2266. Information about the benefits and potential life-saving cures emerging from umbilical cords, rich in stem cells, should be made available to all women who are pregnant. The amazing progress science is making in adult stem cell research holds such promise for our children. Most people are unaware of these opportunities to provide a possible "insurance policy" for their children, so the state and medical providers would be doing a great service to the citizens of the state. In addition, for those women who want to donate their children's umbilical cords, this provides an opportunity to participate on the cutting edge of science without encountering the ethical problems of embryonic stem cell "harvesting."

It is essential that women know the opportunity exists for the umbilical cords of their children to be stored in case a medical condition arises later in that child's life that could be treated with stem cells. Those stem cells contained in the umbilical cords of their infant are exactly matched to their child so rejection problems would be avoided. In the case umbilical cords donated for general use, host rejection is far less with stem cells derived from umbilical cords than from other donor tissues.

We have a unique opportunity to leave a legacy of monumental proportions to our children with this bill. This is a small step toward ensuring that ethical and non-controversial medical cures and treatments will be available to our next generation.

We urge you to support this bill.

Judy Smith, State Director
Concerned Women for America of Kansas

DEPARTMENT OF HEALTH
AND ENVIRONMENT
Division of Health

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on
Umbilical Cord Donation Information Act, HB 2266

House Health & Human Services Committee

Presented by
Dick Morrissey, Deputy Director of Health
March 8, 2007

Chairperson Landwehr and members of the Committee, I am Dick Morrissey, Deputy Director of the Division of Health in the Kansas Department of Health and Environment. Thank you for the opportunity to speak to HB 2266, which requires KDHE to furnish information about umbilical cord blood banking to health care providers in Kansas.

In providing information about umbilical cord blood banking within Kansas, KDHE will be relying on the expertise and guidance of professional organizations with a keen interest in the subject. We wanted to inform the committee of some of the contents of these recommendations which would become part of our educational efforts. For example, in January of this year, the American Academy of Pediatrics issued a revision (attached) of its 1999 position statement on cord blood banking. In summary, physicians are advised to provide the following information to prospective parents:

1) Cord blood banking should be discouraged for later personal use. MDs should be aware of unsubstantiated claims of private cord blood banks about 'banking as insurance' against future serious illness in the infant or family. Directed banking should be encouraged when there is knowledge of a full sibling in the family with a medical condition that could potentially benefit from cord blood transplantation.

2) Cord blood banking should be encouraged when the cord blood is stored in a bank for public use. If genetic or infectious diseases are identified in testing, the family will be notified. The banked material may not be accessible to the family for future use.

3) Private storage of cord blood as "biological insurance" should be discouraged. Cord blood banks should comply with national accreditation standards (FACT), FDA, FTC, and similar state agencies. At a minimum MDs involved in procurement of cord blood should be aware of collection, processing, and storage procedures.

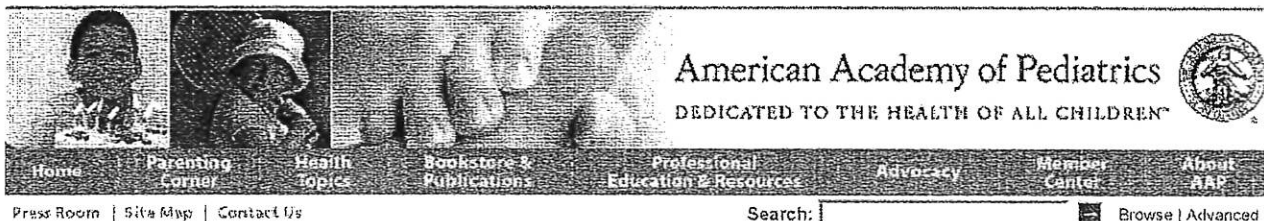
House Health and Human Services
DATE: 3-8-07
ATTACHMENT 6-1

OFFICE OF THE DIRECTOR OF HEALTH
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 300, T
Voice 785-296-1086 Fax 785-296-1562

At the present time there are no accredited cord blood banks in Kansas, public or private. The nearest accredited public cord blood bank is in St. Louis. Due to the very substantial cost in startup and ongoing operation of a public cord blood bank, it is uncertain if Kansas will ever "spontaneously" develop a public bank. Pursuant to House Substitute for Senate Bill 84, which was passed last year, KDHE is working closely with the Kansas Bioscience Authority to maximize the chances that an umbilical cord blood bank will be established within the state. We are currently preparing draft regulations and contracts for use once a cord blood bank provider has been identified.

Finally, it is worth noting that umbilical cord blood banking is a technology in continual development. As new banks are established across the country as well as in Kansas, and as further information and research is done in this field, the information distributed by KDHE will require continual updates at an annual cost similar to that of the initial effort.

Thank you for the opportunity to appear before this Committee. I'll be happy to stand for any questions you might have at this time.



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Frequently Asked Questions about Cord Blood Banking

(Posted January 2007)

See related news release: AAP Encourages Public Cord Blood Banking

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1. What is the difference between private cord blood banking and public cord blood banking?

- Private cord blood banking is storing the baby's cord blood for his/her own future use or use for a family member should the need arise. Alternatively, public cord blood banking, or donating, means that the baby's cord blood is stored in a cord blood bank and is available to anyone in need of a transplant or may be used research purposes.

2. I've been approached by a self-storage program to store my child's cord blood. Isn't it better to be safe than sorry? Should I store it or donate it?

Parents should consult their physician to help them make an informed decision.

- Cord blood donation should be encouraged with the cord blood is stored in a bank for public use.
- Private cord blood banking should be encouraged when there is knowledge of a full sibling in the family with a medical condition (malignant or genetic) that could potentially benefit from cord blood transplantation.
- If banking for future personal or family use, parents should know that most conditions that might be helped by cord blood stem cells already exist in the infant's cord blood and would not be used (ie, premalignant changes in stem cells).
- Storing cord blood as "biological insurance" should be discouraged because there currently is no scientific data to support (self) autologous transplantation..

3. Where can I donate cord blood?

- Contact your local hospital to determine if it is affiliated with a cord blood bank or contact any major university hospital or medical center in your state to find out if they accept cord blood donations.

4. Why isn't there a cord blood bank in my area?

- There are only a few cord blood banks in the United States; therefore, donation to a local bank is not possible in many areas. Many communities do not have the technical and financial resources necessary to establish and operate a cord blood bank.

5. Does it cost anything to donate cord blood?

- The public donor cord blood banks pay for the collection procedure and storing of the baby's cord blood, so there is no cost to the family for donating the baby's cord blood. However, there are significant fees associated with private storage of cord blood often including both the collection and the storage.

6. Are there any risks to donating cord blood?

- No, because the cord blood is collected after the baby is born and the umbilical cord is clamped and cut, it does not affect the baby or the birth experience. Cord blood collection should not be performed in complicated deliveries. The cord blood stem cell-collection program should not alter routine practice for the timing of umbilical cord clamping.

7. What will happen to my child's cord blood if I donate it?

- If a family decides to donate a baby's cord blood and there is a cord blood bank in the area, the mother will need to obtain a collection kit that may include a family medical history questionnaire, a consent form, and the collection materials. The informed consent must be signed prior to the onset of active labor and before the cord blood collection. The consent must contain information pertaining to what tests are to be performed on the cord blood and how the parents will be informed should the test results be abnormal. Once a baby's cord blood is collected, it is typed, screened for infectious diseases and for hereditary hematologic diseases. If the donation is large enough and meets all of the required standards, it will be cryogenically stored for potential transplantation if a match is found or it might be used for quality improvement and research.

8. How does donated cord blood help others?

- It can help treat diseases such as malignancies, bone marrow failure, hemoglobinopathies, immunodeficiencies, and/or inborn errors of metabolism.

9. How long can cord blood be stored before it expires?

- Research is ongoing about the storage life of cord blood units.

10. How soon should I notify the cord blood bank in my area that I want to donate?

- The cord blood bank should be notified approximately 4-6 weeks before the due date or about week 34 of pregnancy.

11. If it turns out my child does need the cord blood, can I retrieve his/her's cord blood from the bank I donated to?

- Cord blood banked in a public program might not be available for future private use. Most conditions that might be helped by cord blood stems cells already exist in the infant's cord blood (ie, premalignant changes in stem cells).

12. If I decide to use a private cord blood bank, is there anything specific I should look for when selecting one?

- Does the company bank for personal and family use?
- Institutional Review Board-approved protocols should be in place, including annual disclosure of the financial interest and potential conflicts of interest.
- Financial viability and stability of the company should be considered
- Physician should disclose any potential conflict of interest.
- Company should have an informed consent process in place and require the parent to sign an informed consent.
- Cord blood banks should comply with national accreditation standards developed by the Foundation for the Accreditation of Cellular Therapy (FACT), the US Food and Drug Administration (FDA), the Federal Trade Commission, and similar state agencies.

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American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007, 847-434-4000

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

POLICY STATEMENT

Cord Blood Banking for Potential Future Transplantation

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Section on Hematology/Oncology and Section on Allergy/Immunology

ABSTRACT

In recent years, umbilical cord blood, which contains a rich source of hematopoietic stem and progenitor cells, has been used successfully as an alternative allogeneic donor source to treat a variety of pediatric genetic, hematologic, immunologic, and oncologic disorders. Because there is diminished risk of graft-versus-host disease after transplantation of cord stem cells using matched related donors, the use of less-than-completely matched HLA cord blood stem cells may incur less risk of graft-versus-host disease than mismatched cells from either a related or unrelated "walking" donor, although this remains to be proven. Gene-therapy research involving modification of autologous cord blood stem cells for the treatment of childhood genetic disorders, although experimental at the present time, may prove to be of value. These scientific advances have resulted in the establishment of not-for-profit and for-profit cord blood–banking programs for allogeneic and autologous cord blood transplantation. Many issues confront institutions that wish to establish or participate in such programs. Parents often seek information from their physicians about this new biotechnology option. This document is intended to provide information to guide physicians in responding to parents' questions about cord blood donation and banking and the types and quality of cord blood banks. Provided also are recommendations about appropriate ethical and operational standards, including informed consent policies, financial disclosures, and conflict-of-interest policies for physicians, institutions, and organizations that operate or have a relationship with cord blood–banking programs.

INTRODUCTION

In a number of genetic, hematologic, immunologic, metabolic, and oncologic disorders, reconstitution of bone marrow (transplantation) can be a potentially life-saving procedure.[1–16] Allogeneic (related or unrelated) or autologous (self) bone marrow or peripheral blood stem cells are the usual sources of hematopoietic progenitor cells to achieve this goal. If autologous stem cells are not available or cannot be used, the best option for successful reconstitution therapy is to secure stem cells from an HLA-matched sibling.[1,3,11] Close matching confers a higher probability of successful engraftment and minimizes the risk of potentially fatal graft-versus-host disease. Unfortunately, there is only a 25% chance for identifying a full HLA match in a sibling donor.[17,18]

An alternative to a related donor involves seeking unrelated HLA-matched adult allogeneic donors outside of the family.[2,6,11] There are more than 7 million potential unrelated volunteer adult donors registered in the National Marrow Donor Program registry.[17] Although the number of patients who receive unrelated

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doi:10.1542/peds.2006-2901

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

Key Words
cord blood, stem cells, hematology, oncology

Abbreviations
FACT—Foundation for the Accreditation of Cellular Therapy
FDA—US Food and Drug Administration

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6-5

adult allogeneic donor stem cell transplants continues to increase each year, many patients are unable to find a fully matched donor, which diminishes access to transplantation therapy. Nonwhite patients have a lower chance of identifying a fully matched unrelated adult donor because of genetic heterogeneity and lack of nonwhite donors. Over the past decade, unrelated-donor, banked umbilical cord blood has been shown to contain sufficient numbers of stem cells for successful transplantation between unrelated, partially HLA-mismatched individuals.[19–23] With advances in the clinical practice of cord blood transplantation, most patients unable to find a fully matched adult donor can identify a partially matched cord blood donor.

Recently, it was shown that umbilical cord blood contains a sufficient number of hematopoietic stem cells to be used for transplantation. More than 5500 unrelated-donor cord blood stem cell transplants for a variety of pediatric genetic,[22,24–31] hematologic,[22,24,25,29,32] immunologic,[28] metabolic,[26,27,30] and oncologic[19,20,33–36] disorders have been performed to date (Table 1). The 1-year survival may be as high as 75% to 90% after sibling HLA-matched cord blood donor stem cell transplantation[21,24,29] and 40% to 80% after unrelated cord blood stem cell transplantation.[19,20,26,27,33,35,36] Advantages of the use of cord blood include the fact that it is readily available, carries less risk of transmission of blood-borne infectious diseases, and is transplantable across HLA barriers with diminished risk of graft-versus-host disease compared with similarly mismatched stem cells from the peripheral blood or bone marrow of related or unrelated donors.[21,34,35,37] Autologous stem cells[38,39] have been used for gene therapy in infants with severe combined immunodeficiency, but the appearance of T-lymphocyte leukemia in some patients has indicated the need for more basic research before additional clinical trials of gene therapy can be undertaken.

Since the first unrelated cord blood–banking program was started at the New York Blood Center in 1991,[40] a number of public cord blood–banking programs have been established throughout the world to collect, type, screen for infection, and cryogenically store cord blood for potential transplantation to unrelated and related recipients.[41–49] Some of these programs had been funded by the National Heart, Lung, and Blood Institute (National Institutes of Health), the National Marrow Donor Program, the American Red Cross, or academic programs based in not-for-profit organizations. One cord blood program initiated by the National Institutes of Health exists solely for sibling donor collection for families who are likely to consider cord blood transplantation because a first-degree relative has been diagnosed with a disease that is treatable with allogeneic transplantation. In this bank, families own the cord blood, and it is shipped to a designated transplant center in the event a medical decision to proceed with cord blood transplantation is made.[50]

TABLE 1 Diseases Treatable With Umbilical Cord Blood Transplantation

Malignancies
Bone marrow failure
Hemoglobinopathies
Immunodeficiencies
Inborn errors of metabolism

A number of private for-profit companies have been established that encourage parents to bank their children's cord blood for their own autologous use or for directed donor allogeneic use for a family member should the need arise. Parents have been encouraged to bank their infants' cord blood as a form of "biological insurance." Physicians, employees, and/or consultants of such companies may have potential conflicts of interest in recruiting patients because of their own financial gain. Annual disclosure of the financial interest and potential conflicts of interest must be made to institutional review boards that are charged with the responsibility of mitigation of these disclosures and risks. Families may be vulnerable to the emotional effects of marketing for cord blood banking at the time of birth of a child and may look to their physicians for advice. No accurate estimates exist of the likelihood of children to need their own stored cord blood stem cells in the future. The range of available estimates is from 1 in 1000 to more than 1 in 200 000.[51] The potential for children needing their own cord blood stem cells for future autologous use is controversial presently.[51] There also is no evidence of the safety or effectiveness of autologous cord blood stem cell transplantation for the treatment of malignant neoplasms.[51] Indeed, there is evidence demonstrating the presence of DNA mutations in cord blood obtained from children who subsequently develop leukemia.[52] Thus, an autologous cord blood transplantation might even be contraindicated in the treatment of a child who develops leukemia.

Cord blood has been shown to contain pluripotent stem cells that have the potential to differentiate into nonhematopoietic tissue, such as cardiac, neurologic, pancreatic, and skin tissue, in vitro.[53,54] Extensive laboratory research is taking place to explore the potential therapeutic benefit of cord blood under these circumstances. The results of this research will be necessary to formulate future recommendations regarding autologous cord blood banking.

Initially, cord blood stem cell transplantation using allogeneic umbilical cord blood was performed in relatively small children, because the cell dose per weight of recipient was shown to be important.[19,20] However, older children, adolescents, and adults have benefited from unrelated allogeneic umbilical cord blood transplantation.[34,55–61] Because of the relationship between cell dose

6-6

per recipient weight and transplant outcome, the number of cord blood cells needed for marrow reconstitution in older children or young adults is much larger than that needed when cord blood is used for transplantation in small children. Cord blood transplants using multiple cryopreserved units from separate donors have been performed successfully in adults, and the approach is currently under investigation as a strategy to increase the dose of cells for transplantation in a single recipient.[62] Cord blood is collected in observance of good obstetric and pediatric practice.[45]

Although cord blood is currently considered discarded human material, it should only be collected for banking with an institutional review board–approved protocol and with signed informed consent from a parent.[42,43] Pertinent donor information communicated to the cord blood bank should be kept confidential by the cord blood bank and used only to report important medical information obtained during the cord blood collection, processing, and screening process that is relevant to the safety of the donor and family. If cord blood was collected from a newborn who subsequently developed a genetic, immunologic, or malignant neoplastic disorder, parents should notify the cord blood bank so that the unit is not used for transplantation. All cord blood units banked for potential use should be tested for infectious diseases, similar to those tested in a blood bank, and for hereditary hematologic diseases. The informed consent must contain information pertaining to what tests are to be performed on the cord blood and how the parents will be informed if test results are abnormal. Pediatricians should be aware that legal cases relating to the duty of a physician to warn parents about the risks of inheriting a genetic disease are new and untested. Pediatricians should remain vigilant, because future cases may define who has a legal duty to notify parents about genetic abnormalities identified during cord blood testing. Informed consent should be obtained before the onset of active labor and before cord blood collection.

RECOMMENDATIONS

Cord blood transplantation has been shown to be curative in patients with a variety of serious diseases. Physicians should be familiar with the rationale for cord blood banking and with the types of cord blood–banking programs available. Physicians consulted by prospective parents about cord blood banking can provide the following information:

1. Cord blood donation should be discouraged when cord blood stored in a bank is to be directed for later personal or family use, because most conditions that might be helped by cord blood stem cells already exist in the infant's cord blood (ie, premalignant changes in stem cells). Physicians should be aware of the unsubstantiated claims of private cord blood banks made to future parents that promise to insure infants or family members against serious illnesses in the future by use of the stem cells contained in cord blood. Although not standard of care, directed cord blood banking should be encouraged when there is knowledge of a full sibling in the family with a medical condition (malignant or genetic) that could potentially benefit from cord blood transplantation.
2. Cord blood donation should be encouraged when the cord blood is stored in a bank for public use. Parents should recognize that genetic (eg, chromosomal abnormalities) and infectious disease testing is performed on the cord blood and that if abnormalities are identified, they will be notified. Parents should also be informed that the cord blood banked in a public program may not be accessible for future private use.
3. Because there are no scientific data at the present time to support autologous cord blood banking and given the difficulty of making an accurate estimate of the need for autologous transplantation and the ready availability of allogeneic transplantation, private storage of cord blood as "biological insurance" should be discouraged. Cord blood banks should comply with national accreditation standards developed by the Foundation for the Accreditation of Cellular Therapy (FACT), the US Food and Drug Administration (FDA), the Federal Trade Commission, and similar state agencies. At a minimum, physicians involved in procurement of cord blood should be aware of cord blood collection, processing, and storage procedures as shown in Table 2.

Institutions or organizations (private or public) involved in cord blood banking should consider the following recommendations:

1. Cord blood–banking recruitment practices should be developed with an awareness of the possible emotional vulnerability of pregnant women and their families and friends. Efforts should be made to min-

TABLE 2 Recommended Procedures for Related and Unrelated Cord Blood Banking[45]

Cord blood should be collected in a bag containing citrate-phosphate-dextrose anticoagulant
Cord blood should be processed and frozen within 48 h of collection
Standardized freezing and storage conditions should be followed (FACT)
Segments should be attached to the cord blood for testing and confirmation of identity
Extra cells and plasma should be stored for potential additional testing
FDA regulations regarding infectious disease testing should be followed
Banks should be accredited by FACT and follow FACT cord blood banking standards
Cord blood units should be stored under liquid nitrogen or at equivalent temperatures

6-7

imize the effect of this vulnerability on cord blood–banking decisions.

2. Accurate information about the potential benefits and limitations of allogeneic and autologous cord blood banking and transplantation should be provided. Parents should be informed that autologous cord blood would not be used as a stem cell source if the donor developed leukemia later in life. Parents should recognize that there are no scientific data to support the claim that autologous cord blood is a tissue source proven to be of value for regenerative medical purposes. The current standard uses of cord blood transplantation are listed in Table 1.
3. A policy should be developed by cord blood banks regarding disclosing to the parents any abnormal findings in the harvested blood.
4. Specific permission for maintaining demographic medical information should be obtained, and the potential risks of breaches of confidentiality should be disclosed.
5. Written permission for obtaining cord blood should be obtained before onset of active labor.
6. If the cord blood bank is conducting research, an institutional review board must review and approve recruitment strategies and consent forms.
7. Cord blood collection should not be performed in complicated deliveries. The cord blood stem cell–collection program should not alter routine practice for the timing of umbilical cord clamping.
8. Regulatory agencies (eg, FDA, Federal Trade Commission, and state equivalents of these federal agencies) are encouraged to have an active role in providing oversight of the cord blood program. All cord blood–banking programs should comply with FACT or equivalent accreditation standards.
9. Physicians or other professionals who recruit pregnant women and their families for for-profit placental cord blood stem cell banking should disclose any financial interest or other potential conflict of interest they have in the procedure to their patients.
10. Professionals affiliated with institutions or organizations that promote for-profit placental blood stem cell banking should make annual financial-disclosure and potential-conflicts-of-interest statements to an appropriate institutional review committee that possesses oversight authority.
11. Targeted efforts should be made to recruit underserved minorities (black, Hispanic, American Indian/Alaska Native individuals) in public cord blood–banking programs to extend to them potential treatments afforded other segments of society.

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6-10

Kansas Department of

Social and Rehabilitation Services

Don Jordan, Secretary

House Committee on Health and Human Services
March 8, 2007

HB 2503: Child Support Enforcement Insurance Liens

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House Health and Human Services
DATE: 3-8-07
ATTACHMENT 7-1

Kansas Department of Social and Rehabilitation Services
Don Jordan, Secretary

House Committee on Health and Human Services
March 8, 2007

HB 2503: Child Support Enforcement - Insurance Liens

Chairperson Landwehr and members of the committee, I am Candy Shively, Deputy Secretary for Integrated Service Delivery at the Kansas Department of Social and Rehabilitation Services. Thank you for the opportunity to speak in support of HB 2503, our proposal concerning the SRS Child Support Enforcement Program and liens on insurance proceeds.

Lack of child support income is an ongoing challenge for many families today. In the 132,000 cases served by the CSE Program, 54 percent of children receive the monthly financial support to which they are entitled. That performance, although meaningful to many Kansas families, has placed Kansas only 37th in state rankings. Within our own federal region, Kansas lags far behind Nebraska (#7) and Iowa (#16).

HB 2503 is intended to improve Kansas' success rate for efficiently and effectively enforcing support orders when they go unpaid. This bill expands existing enforcement remedies by creating procedures to identify and intercept certain types of insurance proceeds otherwise payable to support debtors.

Kansas law presently provides an automatic lien on personal property for nonpayment of support. Our proposal sets out the procedure for attaching such a lien to two types of insurance proceeds. It requires SRS to establish a process, with emphasis on automation and speed, that will allow insurers to determine whether a child support lien exists whenever a workers compensation or personal injury insurance claim has been made and a payment to the individual is pending. By addressing only those claims payable directly to the support debtor, this measure avoids affecting payments to third-party providers such as doctors, attorneys, or hospitals. When fully implemented, we anticipate this change in Kansas law will produce over $1,000,000 per year in new support collections, most will flow directly to families.

In theory these insurance payments already are available to families who are owed support by way of garnishments and other legal process. The reality, however, is that too often our workers first learn about the insurance settlement long after the

proceeds have been paid out and spent, leaving the dependent children without a meaningful remedy. By identifying insurance claimants who are support debtors very early in the process, this measure provides much-needed protection for the family's support claim while ensuring that insurance claimants have a meaningful opportunity to raise objections and achieve appropriate results or compromises.

Like a number of states, we propose to contract the functions of conducting matches with insurers, such as: Outreach to establish working relationships, developing and testing interfaces, and ongoing technical assistance and support for participating insurers. The proposed method for identifying settlements payable to support debtors is modeled on the contract processes in use by Iowa, Nebraska, Missouri, and 13 other states. It is intended to accommodate both those insurers who prefer a quick and secure method for checking an individual insurance claimant when the claim is made, and any insurers who prefer processes that are performed automatically in batches.

HB 2503 also proposes streamlining existing administrative enforcement procedures to eliminate ambiguities and to allow them to be used quickly and effectively to enforce an insurance lien. Using these administrative processes will:

- Minimize the impact of these liens on court dockets and resources,
- Provide aggrieved persons options for prompt administrative or judicial review,
- Use legal staff only when complex issues or circumstances require, and
- Minimize the administrative burden on insurance carriers who prefer the automation options available through administrative procedures.

Kansas has a recent history of enacting progressive laws to protect and provide for our children, reflecting the high value that we as a people place on our most vulnerable citizens. This measure builds on that history and affirms that children continue to hold that priority today.

This concludes my testimony. I will be glad to stand for questions.

Child Support Enforcement Fact Sheet

January 9, 2007

The Kansas Child Support Enforcement Program, operating under Title IV-D of the federal social security act, has two purposes: (1) to promote genuine financial stability for households with children, and (2) to ease somewhat the taxpayers' burden for public assistance provided to children not being supported by both parents. By pursuing these twin goals CSE helps families become and remain independent of public assistance, which in turn allows the State to manage public resources more effectively on behalf of all Kansans. CSE's work also enables custodial parents to take the initiative in expanding their children's opportunities to learn, grow up healthy, and develop talents and abilities to the fullest—a vital investment in Kansas' future.

The Kansas CSE Program. The Department of Social and Rehabilitation Services is the designated Title IV-D (CSE) agency for the State of Kansas. CSE operates within the Integrated Service Delivery Division of SRS.

The Kansas CSE Program is a multifaceted operation that combines state, county, judicial, and private resources to meet detailed federal requirements concerning all phases of operation. CSE services include:

- Locating noncustodial parents and their assets;
- Establishing parentage, as needed;
- Establishing support orders, including medical coverage;
- Ensuring regular payment of support through income withholding orders;
- Enforcing support through administrative actions, such as passport denial or interception of tax refunds, lottery winnings, and unemployment benefits;
- Enforcing past due support through court actions, such as garnishment of bank accounts;
- Modifying ongoing support orders, as needed, to reflect the child's current needs and the parents' ability to provide support; and
- Receiving and disbursing support payments through a statewide unit, the Kansas Payment Center.

Outsourcing CSE Functions. These various CSE services are provided across Kansas not only by full and part-time SRS staff, but also by more than 20 contractors selected through competitive procurement. CSE's enforcement contractors presently include a county prosecutor, several district court trustees, and an assortment of private sector providers. Other CSE private contractors are

the vendor operating the Kansas Payment Center, a paternity testing laboratory, credit bureaus, and process servers.

Strategic use of outsourcing allows CSE to remain compliant with federal requirements, to compete more effectively with other States for federal incentives, and to tap expertise and specialized services that are not readily available within the public sector. Competitive procurement allows the State to obtain good value by balancing high standards for performance with competitive pricing.

Before SRS prepares a formal request for proposals (RFP), vendors—including potential bidders—are often invited to share their educational information about successful or innovative solutions. Such background information is often helpful in preventing costly mistakes or adapting cutting-edge ideas to Kansas' particular needs. The RFP itself is prepared by knowledgeable CSE staff in collaboration with Department of Administration's procurement staff. They also draw upon the experience and resources of Kansas CSE and SRS staff, other key stakeholders (for example, the Office of Judicial Administration), other state CSE programs, and the federal Office of Child Support Enforcement.

Once the RFP is published by Department of Administration, Kansas law imposes a "quiet period" during which contact with potential vendors and anyone else concerning the subject of the RFP is strictly limited and controlled. For example, SRS staff involved with the RFP are forbidden to comment even to other SRS staff about the pending procurement except as authorized by Dept. of Administration. In Kansas, this quiet period extends from publication of the RFP until the Dept. of Administration announces that the final contract has been signed by all necessary parties. The quiet period can be quite frustrating and difficult to observe, but its purpose is to assure that no bidder gains an unfair advantage—an advantage which would likely work against the best interests of the State of Kansas.

An important outsourced function that CSE administers is the Kansas Payment Center (KPC), a joint venture between CSE and the Office of Judicial Administration. The KPC is Kansas' central unit for receiving and disbursing all support payments—both in CSE and non-CSE (i.e., private) cases—ensuring that an accurate history of payments is available to the courts and interested parties. Before the KPC was created in 2000, this function was performed in the local district courts. The district courts continue to provide certified payment records upon request, and they enter or update data in the KPC database for new and modified orders as they are issued.

The KPC offers a number of customer-friendly functions statewide, including 24-hour access to payment and disbursement information by telephone or via the Internet, toll free customer assistance for parents and employers, and direct deposit of support disbursements. Taken together, these elements have enabled families to monitor support payments independently and use up-to-date information for planning and managing their household expenses. Successful as the initial procurement has been, SRS and OJA recently took advantage of the second round of KPC procurement to increase the expectations for KPC operations. When fully developed and implemented, these advances in electronic services will offer Kansas parents who pay or receive support additional conveniences and options. As implementation progresses, SRS will report regularly to the Legislature's Joint Committee on Information Technology.

The CSE Caseload. The CSE caseload consists of approximately 132,000 cases serving over a quarter million people. CSE cases fall into two broad categories:

- *Temporary Assistance to Families (TAF).* When a child's custodian applies for Temporary Assistance to Families, that child's support rights are assigned to the State. If CSE collects support in a TAF case, it is used to reimburse the state and federal governments for public assistance provided to the child's family. Any collections beyond the claim for reimbursement are passed on to the family. If the TAF eligibility worker determines that monthly child support collections regularly exceed the monthly TAF grant, the TAF cash grant may be ended. When that happens, appropriate transitional services and supports for the family continue, including CSE services.

- *Non-TAF.* Federal law requires the CSE Program to provide services to any family, regardless of income, that applies for support enforcement services. CSE is also required to provide Non-TAF services when a family stops receiving cash TAF benefits, at the custodial parent's discretion. The idea is to prevent the need for TAF and other forms of public assistance by insuring reliable child support income, and to provide equal treatment under the law for all children. It is important to note that over two-thirds of Kansas Non-TAF families formerly received public assistance.

  The CSE Non-TAF caseload also includes families that are receiving only Child Care Assistance, Food Assistance, or Medical Assistance. When CSE successfully collects support in such a case, current support (and any

past due support that is not subject to an SRS claim for reimbursement) goes directly to the family. For a family receiving Child Care Assistance, this child support income enables them to make their child care co-payments and, after Child Care Assistance ends, pay independently for child care services from the provider of their choice. In similar fashion, child support income that goes to families receiving Food or Medical Assistance helps them to transition more smoothly to financial independence.

Although SRS normally deducts a 4% cost recovery fee from Non-TAF collections, families receiving Child Care Assistance, Medicaid, or Food Assistance are all exempt from the fee. In addition, all of SRS' CSE cases are automatically exempt from any district court trustee fee that might otherwise apply.

CSE funding streams. Kansas currently funds the CSE Program from five sources:

- *Title IV-D federal financial participation (FFP).* The current FFP rate for eligible CSE administrative costs is 66%. To qualify for IV-D federal funds, the Kansas CSE Program must be in compliance with IV-D state plan requirements.

- *Title IV-D federal incentive payments based on performance.* Since 1997, incentive payments have been allocated to the States from a capped pool of federal funds; in effect, the States compete with each other for those funds. Allocations are based upon a complex formula that factors in the size of the State's program (Kansas represents 1% of the national caseload) and the State's performance in five areas: collection of current support, collection of past due support, paternity establishment, establishment of support orders, and cost-effectiveness. To qualify for IV-D federal funds, the CSE Program must be in compliance with IV-D state plan requirements.

  Effective October 1, 2007, States will no longer be allowed to use incentives earned for CSE performance as the State match for IV-D FFP. Federal law continues to require CSE incentives to be reinvested in the State IV-D program, however.

- *The State's share of retained support collections (i.e., reimbursement).* For cases in the TAF or federally-funded foster care programs, Kansas keeps

40% of any collections that are retained under federal law for reimbursement of assistance; the other 60% goes to the federal government. For cases in state-funded assistance programs, Kansas retains 100% of such collections because there is no federal share to be paid. The State's share of collections for both categories represents only 10% of all CSE collections during the year.

Not later than October 1, 2009, the federal rules defining which collections may be retained for reimbursement will change, requiring more collections to be disbursed to families. Although this change will be beneficial to families leaving public assistance, it will erode the ability of the Kansas CSE Program to pay for itself.

- *IV-D cost recovery fees.* Currently, a 4% cost recovery fee is charged on all collections for cases not currently open for TAF, Medical Assistance, Food Assistance, or Child Care Assistance. Under federal law, 66% of this IV-D program income from fees must go to the federal government.

- *State general funds.* State general funds are only required for any portion of CSE Program costs that exceed CSE's total revenue from federal funding, the State's share of support collected and retained, and IV-D cost recovery fees. Until recently, state general funds have not been needed to fund the CSE program. However, the cap on federal incentive payments that may be earned, the new prohibition against using incentive payments as the state match, and the newly-enacted limits on State-retained collections all make it more likely that state general funds will be needed in the future to fund CSE services at their present level and to maintain compliance with federal requirements.

Other facts about the Kansas CSE Program.

- In state fiscal year 2006, CSE's annual support collections reached nearly $161 million, about 75% of which was passed on to families. Altogether, nearly 2.2 *billion* dollars of support have been collected for families and taxpayers since the Kansas IV-D program's inception in 1976.

- In state fiscal year 2006, CSE established over 10,600 child support obligations. The Child Support Guidelines, established by the Kansas Supreme Court, are used to calculate all current support orders in Kansas. The Kansas Guidelines call for work-related child care expenses and the

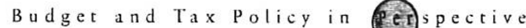
child's health insurance premiums to be factored into the monthly support award, so that the parent who actually pays for child care and/or health coverage will receive a fair contribution toward that expense from the other parent. When appropriate, CSE also establishes a medical support order that specifically requires group health coverage for the child.

- Paternity establishment by the CSE Program also plays a vital role in the SRS mission. Children benefit from having their parentage established because it opens the avenue to cash and medical support from the second parent, assures them access to complete family medical information, and paves the way for potential inheritance and other rights. It also gives the child certainty about his or her family background, which is so important to the child's emotional development and confidence.

- Federal rules permit TAF cash assistance to be ended when current support payments regularly exceed the cash grant. Such closures provide significant advantages to the State, allowing scarce public assistance resources to be focused on the people most in need. CSE services to the former TAF family continue automatically, providing a safety net that reduces the risk of the family returning to dependence on public assistance. This is especially important for people affected by the five-year lifetime limit on TAF eligibility.

- Whenever CSE secures regular child support income for a household receiving Child Care Assistance, Kansas has the opportunity to stretch its limited child care funds a bit further and help additional working families. Dependable income from child support gives a working parent greater confidence that, in spite of ups and downs in public child care funding, he or she will be able to purchase child care services that the family needs.

FISCAL FOCUS



April Holman
Legislative Testimony
House Bill 2503
House Health and Human Services Committee
March 8, 2007

Good afternoon Chairman Landwehr and members of the Committee. On behalf of Kansas Action for Children (KAC), I would like to thank you for this opportunity to testify in favor of House Bill 2503.

KAC is a not-for-profit child advocacy organization that has been in existence since 1979. We advocate for policies and programs that ensure and improve the physical, emotional, and educational well-being of all Kansas children and youth.

We support House Bill 2503, which would provide for insurance and workers compensation liens on proceeds to parents who are not in compliance with child support payments.

The Importance of Child Support

Child support is a critical source of support for many Kansas children growing up in single-parent households. As we look at ways to assist vulnerable Kansans with limited state and federal dollars, it is clear that child support is an effective and efficient support.

At the child development level, children whose noncustodial parents pay child support have more contact with them, potentially providing the children with emotional as well as financial support. Research indicates that children with parental contact have better grades, better test scores, and fewer behavior problems. They also remain in school longer.

Reason for Child Support Arrearages

Although there are numerous reasons for inconsistent or no child support payments, common themes emerge. There are certain child support debtors who are very difficult for the state to communicate with and even locate. These debtors included parents with a sporadic work history, who are self-employed, or receive their wages in cash.

Other states have successfully found these debtors and helped families collect child support payments using this tool. Nebraska, Missouri, and Iowa are neighboring states that all currently have a similar insurance matching process.

Match and Liens on Insurance Proceeds

This mechanism would allow certain insurance payments to be matched against a list of child supports debtors. In the case of a match, the state would be notified, allowing time to notify the insurance company that there is a lien for unpaid support. When the settlement is actually paid,

the insurance company pays the child support debt before sending the rest of the insurance settlement to the debtor.

HB 2503

Experience in other states makes it clear that Kansas can do a better job helping families to receive child support. HB 2503 will give Kansas an effective and efficient tool that can decrease families' dependence on public assistance. Therefore we respectfully request your support of HB 2503.

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An initiative of Kansas Action for Children

KANSAS HOUSE HEALTH and HUMAN SERVICES COMMITTEE
PAUL JOHNSON – KANSAS CATHOLIC CONFERENCE
TESTIMONY IN SUPPORT OF HB 2503 – MARCH 8, 2007

Thank you for this opportunity to testify in favor of HB 2503 that will help target workers compensation and personal injury payments to child support obligations. This legislation would be one more tool - in addition to sanctioning drivers and recreational licenses - to help support the 175,511 children in the SRS IV-D child support cases.

Kansas ranks 38th out of the 50 states in collecting current child support. The 66,405 IV-D cases with current support ordered should be generating $15.4 million a month but only 55% ($8.5 million) is presently being collected. For the record, total child support arrearages have now increased to $610 million. Complete statistics on the SRS IV-D cases are on the back of this testimony.

If this legislation passed, Kansas would be joining 23 other states that have some child support collection procedures with these two forms of insurance. There is a fiscal note of $134,000 in the first year of implementation, $16,000 in year two but a positive payment of $51,000 to the CSE program in year three and forward. The conservative estimate of increased child support collections would be an annual $850,000 by year three. Once this collection tool is fully understood in Kansas, the implementation of this law should become more efficient and the annual child support collections should increase even more.

Child support is a critical income support for thousands of Kansas' children. The Kansas Catholic Conference supports an efficient, parent friendly system of collecting child support. There are many challenges to the child support system in Kansas. The budget for staffing is inadequate given that 44 of the 445 SRS child support employees statewide are kept vacant. The SRS child support computer software system is over 30 years old and struggling to handle 131,000 cases. Kansas does not have a law encouraging financial institutions to match resource data with the SRS child support system. Kansas could move to an administrative system of processing child support cases that would be more accessible for non-custodial parents and initiate the support sooner. **The Kansas Catholic Conference supports an interim study - that would assess the staffing needs, computer capabilities and adequacy of judicial collection tools - of the entire child support system in Kansas.**

House Bill 2503 would be one more collection tool for the SRS child support system. The Kansas Catholic Conference hopes that you will favorably pass this legislation and move it on to law this year.

House Health and Human Services
DATE: 3-7-07
ATTACHMENT 9-1

Child Support Enforcement Statistics

Category Base		Fiscal Year 2006	2005	2004
Ave. Total Caseload		131,694	131,616	134,115
Active Children		175,511	172,135	172,138
Ave. # Collection Officers		201	204	210
Ave Cases per Collection Officer		655	645	640
Collection per Case		1,222	1,188	1,131
Cases with Financial Orders		92,282	91,233	89,061
% with Financial Orders		*70.0%*	*69.0%*	*66.4%*
Cases with Current Support Ordered		66,405	65,421	63,831
% with Current Support Ordered		*50.4%*	*49.7%*	*47.6%*
Total Collections		$160,976,628	$156,391,906	$151,735,429
Support Paid to Families		$127,944,373	$122,970,832	$118,950,065
To Kansas Families		$120,623,526	$116,576,055	$112,779,315
To Families in other States		$7,320,847	$6,394,777	$6,170,750
Fees paid by Families		$2,655,661	$2,594,239	$2,619,591
Ave. Current Support Due for the Month		$15,453,566	$14,608,500	$14,089,804
Ave. Current Support Paid for the Month		$8,544,563	$7,944,810	$7,791,982
Percent of Current Support Paid		*55.3%*	*54.4%*	*55.3%*
Children with Current Support Orders		87,907	86,872	84,943
Total Arrears due		$610,819,512	$576,822,313	$543,022,689
Arrears Collected		$53,348,632	$48,672,827	$47,839,797
Cases with Arrears Due (During the Year)		96954	93,985	92,038
% of Cases with Arrears Due		73.6%	71.4%	68.6%
Average Arrears		$7,000	$6,819	$6,704
Cases with a Payment on Arrears (During Year)		61354	58,555	57,024
Percent Paying on Arrears		*63.3%*	*62.3%*	*62.0%*
TANF related cases		21,446	22,188	21,400
State Debt Only Case	28,306	2,625	3,240	4,107
TAF Foster Care related		2,242	1,794	1,901
GA and JJA Foster Care		4,618	4,581	4,533
Non TANF Cases		93,390	92,617	95,694
Interstate Cases		6,994	7,196	8,381
% of Children with Health Insurance Order		*52.0%*	*46.0%*	*35.0%*
% of TAF Recovered		*35.0%*	*35.2%*	*37.6%*
TAF Cases Closed with support		3,890	3,609	3,326
Current Support Orders Established		10,604	10,332	9,813
Orders Est. per Collection Officer		53	51	47

Kansas Coalition for Workplace Safety

Promoting Economic Security Through Workplace Safety for Kansas Workers and their Families.

- AARP Kansas
- Construction and General Laborers Local 1290 & 142
- Greater KC Building and Construction Trades Council
- Int Assoc of Fire Fighters, Local 64 and Local 83
- International Association of Machinist and Aerospace Workers, Dist. Lodge No. 70
- Kansas ACORN
- Kansas AFL-CIO
- Kansas Fire Service Alliance -- KS State Fire Fighters Assoc, KS State Fire Chiefs Assoc, KS State Prof Fire Chiefs Assoc
- Kansas Association of Public Employees
- Kansas National Education Association
- Kansas Staff Organization
- Kansas State Building and Construction Trades Council
- Kansas State Council of Fire Fighters
- KS State Nurses Assoc
- KS Trial Lawyers Assoc
- Southeast Building and Construction Trades Council
- Teamsters Local No. 696, Local No. 795 & Joint Council 56 KS, MO & NE
- Topeka - Lawrence Building and Construction Trades Council
- Tri-County Labor Counci/Roofers Local #20
- United Auto Workers Local No. 31
- United Steelworkers of America, District 11
- United Steelworkers Local 307
- United Teachers of Wichita
- Wichita Building and Construction Trades Council
- Wichita-Hutchinson Labor Federation of Central Kansas
- Thomas Outdoor Advertising, INC

TESTIMONY IN OPPOSITION OF
HOUSE BILL 2503

BY
JEFF K. COOPER

HEALTH AND HUMAN SERVICES COMMITTEE

Dear Members of the Committee:

Thank you for allowing me to appear in opposition of HB 2503. My name is Jeff K. Cooper, and I am appearing on behalf of the Kansas Coalition For Workplace Safety and the Kansas Trial Lawyers Association. I am an attorney practicing law in Topeka, Kansas, handling primarily workers compensation claims for over 20 years. I also teach workers compensation at Washburn School of Law as an adjunct professor and have taught workers compensation for over 15 years.

I want to make it very clear that I am sure that everyone here today is in favor of protecting and supporting children. The Kansas Coalition For Workplace Safety and the Kansas Trial Lawyers Association certainly are firmly committed to supporting and protecting children in the State of Kansas.

Current Kansas workers compensation law has for many years provided a mechanism to collect child support from workers compensation benefits paid to injured workers. Currently, K.S.A. 44-514, states motions for involuntary assignment of compensation shall be granted for child support. Current law provides as follows:

1. Payment for weekly ongoing benefits of 25% for current support obligations, and

2. 40% of any settlement or award of permanent benefits for payment of past due child support.

Current law only requires that an order from any Kansas Court or any order established under the "Uniform Interstate Family Support Act" shall result in withholding. K.S.A. 44-514 provides a very clear and manageable mechanism for payment of current and past due child support from workers compensation benefits. From my legal experience, I have had a few clients who have had 25% of their weekly benefits withheld for payment of ongoing child support. I have had even fewer clients that have had a portion of their settlement withheld to pay arrearages for child support. While my experience with withholding workers compensation benefits is somewhat limited, I do not recall any problems in any of the cases I have handled.

House Health and Human Services
DATE: 3-8-07
ATTACHMENT 10-1

I believe it is also important to remember that the workers compensation law does not furnish damages for physical injury. Workers compensation law provides for payment of money to or for the benefit of an injured employee, which payments are intended to mitigate the disastrous economic effects of a work injury.

Example: A worker who is earning a gross average weekly wage of $1,000.00 a week prior to an injury, would receive temporary total disability if unable to work in Kansas of $483.00 a week.

Before Injury: $1,000.00 a week

After Injury: $483.00 a week maximum (assuming 2007 injury)

As most of you know, Kansas workers compensation benefits are among the lowest in the Nation. Under current law, 25% of those benefits are subject to withholding for child support, or as in our example $120.75 a week. After child support withholding, weekly temporary total disability benefits paid to the injured worker would be $362.25. Imagine, if you can, living on 50% or 40% or less of your current income.

HB 2503 would make this bleak scenario even worse.

New Sec. 2(b), (Page 1, Line 39) requires the insurer, which would mean every insurance company, group funded pool, self-insured, or other provider to determine if a child support lien exists within 60 days. If on the 60th day the insurance company determined that a child support lien existed, they would be required within three business days to notify the Secretary of Social and Rehabilitation Services by complying with procedures (which are not defined in the statute), and then wait another 15 days before making any payment. In effect, the law would require every insurer to wait 60 days, and possibly over 75 days, before paying any benefits.

Using our prior example of a person who had been earning $1,000.00 a week, now instead of getting $483.00 a week, the injured worker would be required to wait 60 days before even receiving the paltry $483.00 per week in temporary total disability benefits. HB 2503 would have the undesired result of delaying all payments of benefits by a minimum of 60 days.

Imagine the worker's situation if he or she were required to go 60 days without a paycheck. Under current law there is a one week waiting period, and given the drastic reduction in payment of workers compensation benefits under current law, most working people would have difficulty paying the ordinary expenses of daily living. The results of making injured workers and their families do without any paycheck for 60 days would be disastrous. Families would not be able to pay their mortgage or rent, car payments, electricity, bills, etc., and most likely would not even be able to provide food for their families.

Further, *New Sec. 2(c)*, (Page 2, Line 8) apparently would allow the entirety of all workers compensation benefits to be attached. No limitation is provided in the statute with regard to the amount that can be attached. *New Sec. 2(d)*, also appears to create new classes of individuals who can attach workers compensation and, further, appears to allow the payer (insurance company) to determine if any part of the payment is subject to a lien by any other third party, including but not limited to attorneys, doctors, etc., and apparently withhold workers compensation benefits based on payments to a new class of individuals. This section is in direct conflict with K.S.A. 44-514 which provides that "no claim for compensation, or compensation agreed upon, awarded, adjudged, or paid, shall be assignable or subject to levy, execution, attachment, garnishment, or any other remedy or procedure for the recovery or collection of a debt, and this exemption cannot be waived. The only current exception is for payment of child or spousal support under K.S.A. 44-514.

HB 2503 also grants immunity to anybody making a payment to the Secretary, and that immunity is granted against anyone for any issues arising from the payment or delay in payment notwithstanding any other provision in the law (Page 3, Lines 35-39). This Section would, apparently, allow the insurance company to pay the entire amount of an award or benefits to the Secretary without any obligation on their part to make a good faith effort to determine the appropriateness of any payment properly payable.

HB 2503 prescribes significant penalties, civil and criminal, for failure to determine if a lien exists. To avoid any possibility of criminal or civil penalties, the insurance company/self-insured employer, etc., will simply wait at least the 60 days to pay any benefits rather than to risk a violation of the provisions of HB 2503.

In summary, the major portions of HB 2503 would radically and unnecessarily change the existing law in the State of Kansas, would impose further obligations on employers and insurance carriers, and would result in long delays in injured workers receiving workers compensation benefits. The changes with regard to payment of child support are not necessary, and the current law provides a mechanism for collection of child support pursuant to a Title IV-D case or any other case for that matter. It should also be noted that K.S.A. 39-7,147 provides that an income withholding order may be entered by the Secretary if no income withholding order is in effect to enforce a support order in a Title IV-D case. It is clear that the Secretary would have no difficulty obtaining an income withholding order under present Kansas law, and therefore, the proposed changes in HB 2503 are not necessary and would result in extreme unintended consequences.

Kansas AFL-CIO

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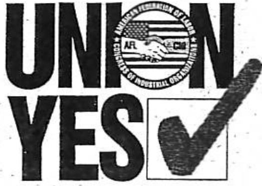

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Richard Taylor
Brian Thompson
Dan Woodard

TESTIMONY IN OPPOSITION TO HB 2503
PRESENTED BY
KANSAS AFL-CIO

HOUSE HEALTH & HUMAN SERVICES

WIL LEIKER
JOHN M. OSTROWSKI
MARCH 8, 2007

Chairperson Landwehr and Members of the Committee:

Thank you for this opportunity to present testimony relative to HB 2503. My name is John M. Ostrowski, and I am appearing on behalf of the Kansas AFL-CIO.

While it is universally agreed that enforcement of child support orders is important, and worthwhile state policy, the Kansas AFL-CIO must oppose HB 2503 in its present form as it relates to workers compensation. It is our position that the bill presents mechanical problems, will raise workers compensation premiums, and essentially "kills the fly with a sledgehammer."

The bill is quite lengthy, but we feel the following are the key points which need to be made to this Honorable Committee.

1. WITHIN THE KANSAS WORKERS COMPENSATION ACT, THERE ALREADY EXISTS A CAREFULLY CRAFTED LIEN TO COLLECT CHILD SUPPORT PAYMENTS.

K.S.A. 44-514 creates an exception to the general rule that no lien can be placed on workers compensation benefits. However, there are "caps" on the amounts of child support/maintenance payments that can be seized. It is a recognition by Kansas (and most other states) that workers compensation benefits represent some minimal wage replacement at a time when a worker (breadwinner) is unable to be engaged in substantial and gainful employment.

Under current law, a worker's weekly check (temporary total disability) can be reduced by 25% for child support; whether the injured worker is current or in arrearage. In addition, if there is an arrearage, 40%

can be taken from any lump sum for a past due support/maintenance obligation. A copy of K.S.A. 44-514 is attached for your ready reference.

This many times leaves the worker with very little weekly income, particularly if the worker was forced to employ an attorney to secure the payment of benefits. It is often the case in today's society that those with existing child support obligations subsequently become heads of additional households by remarriage. Therefore, they are actually contributing to the support of more than one family.

Assume the following scenario:

$831.00 - worker's preinjury wage, $17.50 per hr with 5 hrs OT
- 166.00 - 20% taxes
$665.00 - preinjury net wage

$483.00 - maximum TTD
- 121.00 - attorney's fees
$362.00
- 121.00 - child support payment
$241.00 - net weekly comp

This means that the worker (and his family) is existing on 36% of his preinjury weekly income. Most workers do not anticipate being injured, and live paycheck to paycheck.

As indicated, the legislature has previously determined, as a matter of social policy, to leave the injured worker with some weekly income. It seems readily apparent that without any income (and the bill before this Committee would seize 100% of the worker's income), we are actually going to create additional individuals relying on welfare. It is downward spiral which benefits no one.

2. EVERY CLAIM WILL BE SUBSTANTIALLY DELAYED BY HB 2503.

According to the Kansas Department of Labor, insurers took an average of 110 days from the date disability began to make the first payment to the claimant. (Workers Compensation, 32nd Annual Statistical Report, 2006, p. 117) That means that under the current system, workers are *averaging* 3.66 months from the onset of disability to the first time they receive a payment.

HB 2503 will add significantly to that delay, and an additional 75 days. More specifically, the insurance carrier has 60 days to search for an arrearage, and then must hold the payment for an additional 15 days. This will increase the delay to over 6 months. Recall that this delay is added regardless of whether the injured worker has any arrearage. The carrier does not want to be held subject to penalties by failing to "search the records."

3. HB 2503 WILL INCREASE PREMIUMS FOR KANSAS EMPLOYERS.

We again remind the Committee that this bill impacts every claim filed. No payments will be made by insurance carriers until they have adequately screened the injured worker. While the AFL-CIO is not aware of the percentage of injured workers who actually have some title IV-D obligations, it would seem to be a small number.

Insurance carriers will clearly have to increase their staff to comply with the provisions of this law. Those costs will inevitably be passed on to the employers of Kansas. In essence, we are assuming that the injured worker has an arrearage until he is able to prove otherwise. This cost, coupled with the delay when there already exists a working system to collect child support, seems truly unnecessary.

4. THE BILL IS IN CONFLICT WITH EXISTING LAW FOR TIMELY PAYMENTS.

Workers compensation has its own procedure. Included in that procedure are penalties against insurance carriers for late payments. Generally speaking, the law gives them 20 days to make payments as ordered by the courts. Insurance carriers currently are heard to complain relative to the timelines for compliance. By adding the burdens of HB 2503, it will certainly be more difficult to meet the payment deadlines of the workers compensation act.

5. MEDICAL LIENS.

Section 2(d) of the bill, page 2, lines 19-29, creates a priority lien for "a person licensed to practice medicine and surgery" who "has provided or contracted to provide the claimant with goods or services related to the claim." Payment of medical bills incurred by an injured worker is an extremely complex area of law. It is the subject of litigation and insurance carriers often contest what bills they are obligated to pay. In short, there is often controversy as to whether or not the treatment was provided for a "work related injury."

This bill would appear to pay the medical providers prior to the claimant receiving his weekly check if the medical provider simply notifies the insurance carrier. Again, this is totally inconsistent with the legislature's commitment to workers compensation benefits being protected so that those unable to work have "something to live on."

6. WORK INJURIES OFTEN CREATE AN ARREARAGE.

Child support is determined based on the obligator's income while working. As already has been demonstrated, a worker's income is drastically reduced following injury. When an injured worker is unable to work, he/she often does not seek modification of the child support obligation. Seeking a modification of child support is tedious and expensive. Many workers assume that they will be returning to work more quickly than they are able. In short, child support obligations add "fuel to the fire" of being injured on the job. Clearly, the child support obligations are accumulating faster

than they can be paid. If there was not an arrearage preinjury, the on-the-job injury often creates an arrearage. To further complicate the situation by seizing 100% of the person's weekly income is simply unjustified.

These are the central concerns of the Kansas AFL-CIO relative to HB 2503.

I will stand for questions.

44-514. Payments not assignable; exception, orders for support. (a) Except as provided in subsection (b), K.S.A 23-4,146 or the income withholding act and amendments thereto, no claim for compensation, or compensation agreed upon, awarded, adjudged, or paid, shall be assignable or subject to levy, execution, attachment, garnishment, or any other remedy or procedure for the recovery or collection of a debt, and this exemption cannot be waived.

(b) Claims for compensation, or compensation agreed upon, adjudged or paid, which are paid to a worker on a weekly basis or by lump sum shall be subject to enforcement of an order for support by means of voluntary or involuntary assignment of a portion of the compensation.

(1) Any involuntary assignment shall be obtained by motion filed within the case which is the basis of the existing order of support.

(A) Any motion seeking an involuntary assignment of compensation shall be served on the claimant and the claimant's counsel to the workers compensation claim, if known, the motion shall set forth:

(i) The amount of the current support order to be enforced;

(ii) the amount of any arrearage alleged to be owed under the support order;

(iii) the identity of the payer of the compensation to the claimant, if known; and

(iv) whether the assignment requested seeks to attach compensation for current support or arrearages or both.

(B) Motions for involuntary assignments of compensation shall be granted. The relief granted for:

(i) Current support shall be collectible from benefits paid on a weekly basis but shall not exceed 25% of the workers gross weekly compensation excluding any medical compensation and rehabilitation costs paid directly to providers.

(ii) Past due support shall be collectible from lump-sum settlements, judgments or awards but shall not exceed 40% of a lump sum, excluding any medical compensation and rehabilitation costs paid directly to providers.

(2) In any proceeding under this subsection, the court may also consider the modification of the existing support order upon proper notice to the other interested parties.

(3) Any order of involuntary assignment of compensation shall be served upon the payer of compensation and shall set forth the:

(A) Amount of the current support order;

(B) amount of the arrearage owed, if any;

(C) applicable percentage limitations;

(D) name and address of the payee to whom assigned sums shall be disbursed by the payer; and

(E) date the assignment is to take effect and the conditions for termination of the assignment.

(4) For the purposes of this section, "order for support" means any order of any Kansas court, authorized by law to issue such an order, which provides for the payment of funds for the support of a child or for maintenance of a spouse or ex-spouse, and includes such an order which provides for payment of an arrearage accrued under a previously existing order and reimbursement orders, including but not limited to, an order established pursuant to K.S.A. 39-718a and amendments thereto; K.S.A. 39-718b and amendments thereto; or an order established pursuant to the uniform interstate family support act and amendments thereto.

(5) For all purposes under this section, each obligation to pay child support or order for child support shall be satisfied prior to satisfaction of any obligation to pay or order for maintenance of a spouse or ex-spouse.

Polsinelli | Shalton
Welte | Suelthaus PC

Memorandum

TO: THE HONORABLE BRENDA LANDWEHR, CHAIRMAN
HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

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

RE: H.B. 2503

DATE: MARCH 8, 2007

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the State Farm Insurance Companies. State Farm is the largest insurer of homes and automobiles in Kansas. State Farm insures one out of every three cars and one out of every four homes in the United States. Please accept this memorandum as our opposition of H.B. 2503, and we urge the Committee not take favorable action on the bill.

Section 2(a) provides that a lien is perfected once an insurer has actual knowledge of the lien or when the company is served. This puts an untenable requirement on insurers. What is "actual knowledge" and when will an insurer be deemed to have been put on actual notice. This makes compliance is a significant issue.

Section 2(b) requires an insurer to review information which will be provided by the secretary - "to the maximum extent feasible" - through secure electronic exchange. (Section 3) Does this database currently exist? If the system currently exists we will need sufficient time to review our ability to access and possible download data from an outside database.

Section 2 (d) provides an attorney with a priority lien. We are uncertain as to how this would work.

Section 2 (e) appears to refer to an online reporting form, though again it is unclear whether it currently exists or is to be developed. We report to several state fraud departments online, but the systems review and approval process took some time before we were cleared to use it.

Section 3 requires insures to enter into a confidentiality agreement and section 4 provides for fines for failure to do so. It is not at all clear we can enter into a single agreement as a corporate entity and be insulated from fines. The fine structure seems to imply it has to be done on a transaction basis, which seems absolutely senseless.

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Section 4(b) provides immunity for individual and mechanical errors – does this include errors relating to electronic transmissions?

Section 4(c) provides very broad language granting an insurer immunity for making a payment under this statute. Based on the very broad language of the act, the immunity offers little reassurance. This provision needs to be expanded to make certain an insurer does not become subject to a bad faith claim for delay in payment based on attempts to comply with the act.

Section 5 appears to allow any individual to make a claim for proceeds based on child support arrearage claims. The language of the section subjects insurers to claims from the claimant (for incorrectly withholding payment) and claims of the non-claimant (for incorrectly issuing payment to an insured) and civil fines.

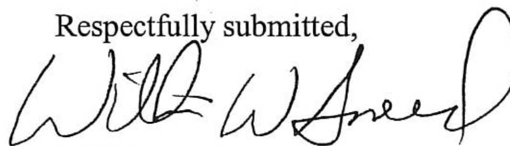
Section 6 (1) and (2) appears to allow for the filing of a lien against a vehicle, watercraft or airplane owned by an obligor. There is no indication whether the original lien holder would be primary and the obligee secondary. In addition why would the obligee be willing to release their lien in a total loss situation if they will not receive any proceeds? Does the lien effect any payment issued for damages or does it only come into play at the time of sale?

We are concerned that this process might artificially inflate claims if the claimant understands that part of the settlement will be going to satisfy a child support lien.

One significant concern with this bill is compliance. The burden is on our claims employees to 'adhere' to the outlined standard of the bill thereby making the claim process more cumbersome. Absent sophisticated automation accurate compliance will be virtually impossible.

Thus, on behalf of my client, we respectfully urge the Committee not take favorable action on H.B. 2503. We would be happy to answer any questions at the appropriate time.

Respectfully submitted,



William W. Sneed

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Testimony on HB 2503
March 8, 2007

TO: **House Health and Human Services Committee**

RE: House Bill No. 2503

Madam Chair and Members of the Committee:

Thank you for this opportunity to present information to the Committee on behalf of KAPCIC, whose members are domestic insurance companies in Kansas, and PCI, the Property Casualty Insurers Association of America, which has over 1,000 member insurance companies in the U.S., and whose member companies have a significant business presence in Kansas writing over 40% of the property-casualty premiums in Kansas.

Our member companies are interested in the concept of assisting the Secretary in getting child support liens paid and would also be willing to work closely with the Secretary in creating a viable plan that would enable a working partnership preferably starting with a voluntary pilot project where most of the technical requirements and problems could be addressed. We feel that the current bill includes several matters that will need further clarification or may lead to problems.

While we understand the intent is only to involve workers' compensation and personal injury insurance payments, the terminology in the bill may need some clarification to achieve that purpose. Also, under New Section 2(b), the language stating that "the insurer shall determine whether a child support lien exists within 60 days but not later than 15 days prior to making the payment" is unclear and would be difficult for insurers to comply with due to the confusing language. Similar language is also used in New Section 2(f) relating to the amount of time an insurer is required to hold the amount subject to the child support lien. We believe this language needs to be clarified to allow timely and consistent compliance.

Likewise, New Section 3 refers generally to "secure electronic data exchanges" in describing how the information regarding child support liens will be communicated to insurers. But does not adequately set forth how the information will be accessed. As insurance claims may be handled by a number of people within a company or outside a company, such access becomes critical. We understand that some other states utilize the Child Support Lien Network (CSLN), which is a multi-state database in which state governments and insurers provide data and can check data on who owes child support in all participating states. Some out of state and

multi-state insurers are already familiar with this database, since it is currently in use in a number of other states that already have child support lien laws. In utilizing a database that has already been created and is being utilized in other states, we would not have to set up or test a new system. More information can be found on CSLN on their website at (http://www.childsupportliens.com/)

Third, our members have some general concerns regarding the bill, including the burden it will place on each individual company, especially our smaller companies, and their staff in handling these claims. In light of those concerns, we would urge the Committee to consider changing the bill and patterning it after the concept included in legislation that has been passed in Tennessee that applies to all financial institutions and not just insurance companies. The Tennessee law also states that "the department of human services shall consult with a representative number of financial institutions and shall avoid the imposition of requirements that are not reasonably compatible with the data processing and recordkeeping systems generally utilized by financial institutions." Such an amendment would allow the department and the companies to work together to ensure that the child support lien requirements are not overly burdensome for the companies, but are still meeting the needs of the department.

At this time, due to the questions our members companies have regarding this bill, we would urge further study and discussion to determine the possible ramifications of such legislation and the potential problems we may face. Thank you for your consideration.

Respectfully,

DAVID A. HANSON

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