Approved: March 10, 2009
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on February 9, 2009, in Room 136-N of the Capitol.

All members were present except Senator Kelly, who was excused

Committee staff present:
- Nobuko Folmsbee, Office of the Revisor of Statutes
- Doug Taylor, Office of the Revisor of Statutes
- Kelly Navinsky-Wenzl, Kansas Legislative Research Department
- Terri Weber, Kansas Legislative Research Department
- Jan Lunn, Committee Assistant

Conferees appearing before the committee:
Phil Griffin, Director of TB Prevention and Control, Kansas Department of Health and Environment
Michael Giessel, MD, Cotton O'Neil Clinic
Darrell Ringler, owner, The Midas Touch Golden Tans
Mary Lou Davis, Executive Director, Kansas Board of Cosmetology
Cyndi Treaster, Director of Farmworker, Refugee, and Immigrant Health, Kansas Department of Health and Environment

Others attending:
See attached list.

Chairman Barnett requested Nobuko Folmsbee, revisor of statutes office, brief the committee members on the bills being heard.

SB 62 - Department of health and environment; tuberculosis evaluation requirements and prevention and control plan for postsecondary educational institutions; rules and regulations.
SB 62 would create new law and amend existing law concerning responsibilities for the prevention and control of tuberculosis in postsecondary educational institutions. The Secretary of Health and Environment is responsible to adopt rules and regulations establishing guidelines for a tuberculosis prevention and control plan for any postsecondary educational institution in the state. The plan is designed to reduce the risk of tuberculosis transmission and is based on the recommendations of the American Thoracic Society, the Centers for Disease Control and Prevention, and the Infectious Diseases Society of America.

SB 101 - Tanning facilities; regulating minors' use of tanning device.
This bill deals prohibits anyone under 14 to receive tanning services and restricts tanning for individuals between 14 and 17 without the written consent of a parent or legal guardian. The written consent must contain language indicating the parent/guardian has read and understands hazards/warnings of tanning, and the parent/guardian must submit proof of the minor's age. The written consent is valid for one year and can be rescinded at any time by the parent/guardian. The Kansas State Board of Cosmetology is required to adopt rules and regulations to implement the act.

SB 170 - Interpreters data bank.
This legislation creates a volunteer interpreter data bank to serve any adult care home, hospital, local health department, community mental health center and other programs or facilities which provide medical, health care, or mental health care services. The Kansas Department of Health and Environment is accountable to maintain and to determine qualifications of interpreters included in the data bank with the assistance of an advisory committee.

Senator Barnett called attention to the attachments which are in follow-up to previous meetings. Therefore, they are incorporated into this permanent record.
Kansas Health Policy Authority follow up to questions heard at the January 13, 2009, Public Health and Welfare meeting concerning the State Employee Health Plan, 2009 healthcare reform initiatives, etc. (Attachment 1)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Minutes of the Senate Public Health And Welfare Committee at 1:30 p.m. on February 9, 2009, in Room 136-N of the Capitol.

Kansas Health Policy Authority follow up to questions heard at the January 20, 2009, Public Health and Welfare meeting concerning the total cost of all incentives and services provided to state employees for health screens in 2008 (Attachment 2).

Kansas Association for the Medically Underserved follow up to questions from the January 21, 2009, Public Health and Welfare meeting concerning specialty care access challenges (Attachment 3).

Kansas Department of Health and Environment follow up to questions from the January 22, 2009, Public Health and Welfare meeting concerning State-Funded Primary Care and Rural Health Clinic Sites by County (Attachment 4).

Kansas Health Policy Authority follow up to questions from the January 26, 2009, Public Health and Welfare meeting concerning heart transplantation reimbursements for children through Kan B Healthy and whether fees for reimbursement are negotiated or set. (Attachment 5)

Terri Weber, legislative research department, furnished 2009 Federal Poverty Guidelines as an informational resource (Attachment 6).

Senator Barnett opened the hearing on **SB 62 - Department of health and environment; tuberculosis evaluation requirements and prevention and control plan for postsecondary educational institutions; rules and regulations.**
Phil Griffin, Kansas Department of Health and Environment, discussed concerns with postsecondary educational institutions, and the fact that many students have not had a tuberculosis screening which places all students, staff, and faculty at risk of contracting tuberculosis (Attachment 7). He indicated this issue is of national concern and many states are struggling to pass legislation similar to **SB 62.** Mr. Griffin discussed individuals vaccinated with BCG and false positives generated when the individual undergoes a tuberculosis skin test (TST). Mr. Griffin indicated the KDHE is committed to working with all partners to achieve attainable results. Senators discussed costs of screening students and of providing therapeutic antibiotic treatment (in the case of a positive tuberculosis diagnosis).

Senator Barnett requested a scientific article about the most recent testing for BCG, and Senator Pilcher-Cook requested data on TB trends in the last 10 years in Kansas. Mr. Griffin indicated that information request would be forwarded to committee members.

Senator Schmidt moved to amend the legislation's effective date as publication in the Kansas Register, to technically amend as recommended by staff, and to favorably pass out **SB 62,** as amended. Senator Brungardt seconded the motion which passed unanimously.

Senator Barnett opened the hearing on **SB 101 - Tanning facilities; regulating minors' use of tanning device.** Senator Barnett introduced Dr. Michael Giessel, a local dermatologist, who spoke in support of **SB 101.** Dr. Giessel explained the types of skin cancer indicating melanoma is one of the most lethal. He cited various scientific studies supporting correlation between tanning beds and melanoma, particularly when beginning tanning at youthful ages (Attachment 8), and requested passage of **SB 101**.

Darrell Ringler, owner of Midas Touch Tanning Salon in Emporia, was recognized to provide testimony (Attachment 9) in opposition to **SB 101.** Mr. Ringler indicated that he requires patrons to use a form/consent in which a patron can identify his/her "skin type" using a table that is provided, employs trained operators to ensure exposure is based on the patron's "skin type as identified in the consent/form," provides protective eyewear, and attempts to ensure that his patrons are educated and informed relative to tanning hazards/warnings.

Mary Lou Davis, executive director of the Kansas State Board of Cosmetology, spoke from a neutral perspective (Attachment 10). Ms. Davis indicated that in 1992, the Board of Cosmetology was given regulatory authority to license and inspect tanning salons. She reminded those attending that in the 2007-08 Session, extensive legislation was passed granting the Board of Cosmetology the ability to deny or revoke licenses, to assess fines, and to cite tanning salons when there has been a failure to follow the law.

Ms. Davis indicated that with the enactment of the Kansas statute in 2008 the Board can facilitate consumer protection. Ms. Davis shared that the fiscal impact of developing a consent form is minimal, the greatest expense would be enforcement should **SB 101** be passed.

Written testimony was submitted by Ann Spiess, American Cancer Society (Attachment 11) supporting the legislation, and Marlee Carpenter, Indoor Tanning Association (Attachment 12) opposing **SB 101**.

Senator Barnett closed the hearing on **SB 101**.

SB 170 - Interpreters data bank.

Chairman Barnett introduced Cyndi Treaster, Kansas Department of Health and Environment, who indicated that while the KDHE supported the concept of an interpreters data bank, there are concerns that the legislation raises (Attachment 13). Ms. Treaster indicated that to be helpful to health entities needing interpreters, the KDHE is required to develop interpreter standards. Therefore, verification of interpreter skills and certification is necessary to ensure precise interpretation. She indicated this process may take several years to develop. The fiscal impact projected is approximately $70,000.

Chairman Barnett called attention to written testimony submitted by Chad Austin, Kansas Hospital Association (Attachment 14), and closed the hearing on **SB 170.**

The next meeting is scheduled for February 10, 2009.

The meeting was adjourned at 2:32 p.m.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Public Health & Welfare
2-9-09

Name	Organization
Michael Geissel	- Dermatologist physician
Mary Lou Davis	KBOC
Carolyn Middendorf	KsSNs Assn
Natalie S. Bright	Indoor Tanning Assoc.
Wendell Riegler	Midas Touch Tanning
Rick Morgan	Oasis Tanning
David Rowe	KU Medical Center
Susan Kang	KDHE
Tracy Russell	KHCC
Dan Morin	KS Medical Society
Dick Morrissey	KDHE
Cyndi Treaster	KDHE
Phil Griffin	KDHE
Ami Hyten	Topeka Independent Living
D. Moyer	KHPA

Chairman Barnett
Senate Committee of Public Health and Welfare
January 27, 2009

Agency Response to Follow Up Questions
KHPA Testimony
January 13, 2009

Public Health and Welfare
Date: 02/09/09
Attachment: 1

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For Plan Year 2009, the Health Care Commission (HCC) changed the philosophy on the employee health insurance premium for a new base rate and a discounted rate. The HCC added a discount of $20 per pay period ($480 annually) off the base rate for those who were non tobacco users and those who were tobacco users but agreed to enroll in a tobacco cessation program. Tobacco users not enrolling in the tobacco cessation program will pay the base rate.

The bottom line for this year with the adjustments to the base rate and those individual who elected not to participate in the discount provides an increase in revenue of $3,222,240 over the base rate for Plan Year 2008.

4. Explain the correlation of Tobacco tax and Indoor Smoking Ban to health. Are their successes in other states?

A large number of studies looking at indoor smoking bans have concluded that not only is there a decrease in smoking there is also a decrease in the risk of cardiovascular disease. These studies looked at similar indoor clean air laws across the United States and world. Provided in this response packet is a bibliography of many of those studies.

- Additional costs occur each year in medical treatment and lost productivity as a result of exposure to secondhand smoke

Source: *Tobacco Use in Kansas 2007 Status Report,* Kansas Department of Health and Environment, http://www.kdheks.gov/tobacco/download/TobaccoReport.pdf accessed January 15, 2009

Tobacco Tax Increases as a Method of Reducing Initiation of Tobacco Use and Increasing Cessation

The American Journal of Preventive Medicine's *Guide to Community Preventive Services: Tobacco Use Prevention and Control* identifies strategies that are most effective in reducing the number of people who start using tobacco and increasing the number who quit. Among the strategies identified is increasing the unit price for tobacco products by raising the product excise tax through legislation. This strategy has proven to be effective based on evidence that it:

- Reduces the overall consumption of tobacco
- Reduces tobacco use initiation
- Increases tobacco cessation

Studies have shown that a 10 percent increase in the price of cigarettes reduces youth consumption by about seven percent and adult consumption by around four percent.1 In addition, an independent panel of scientists convened by the National Institutes of Health (NIH) examined evidence behind a number of interventions to reduce tobacco use in 2006; based on the findings they concluded that increases in the price of tobacco products prevent tobacco use among adolescents and young adults, increase attempts to quit and reduce consumption of tobacco products by all adults.2 The report also noted that the larger the tax increase is, the more significant the reduction in smoking is due to the dramatic increase in price all at once.

A growing number of cities and states are enacting clean indoor air laws combined with increasing tobacco taxes. Twenty four states, Washington D.C., and Puerto Rico have passed clean air laws that cover restaurants and bars. Four other states – Florida, Idaho, Louisiana and Nevada- have clean air laws that cover restaurants but exempt stand-alone bars.3 Examples of a city and state that have successfully used clean indoor air laws and increases in tobacco taxes to significantly reduce the rate of tobacco smoking follow.

New York City

From 2002 to 2006, New York City implemented measures including a large increase in its cigarette tax, a clean indoor air workplace law, and intensive tobacco educational campaigns. The results were significant:

- After a decade with no progress prior to these measures, New York City's smoking rated declined from 21.6 percent in 2002 to 17.5 percent in 2006
- When the decline stalled in 2005, the city began a concentrated year-long media campaign to motivate more smokers to quit in 2006
- From 2005 to 2006, smoking decreased sharply among males (from 22.5% to 19.9%) and among Hispanics (from 20.2% to 17.1%)
- By 2006, there were 240,000 fewer smokers in New York City than there were in 2002, which will prevent an estimated 80,000 deaths from smoking-related causes
- In addition, New York City's high school smoking rate is down to 8.5 percent due to these policies, according to the 2007 New York City Youth Risk Behavior Survey. This rate is:
    - Down from 17.6 percent in the same survey conducted in 2001
    - Way below the national high school smoking rate of 20 percent in 2007

Source: *2008 State Legislated Actions on Tobacco Issues Mid-Term Report,* American Lung Association, www.lungusa.org, accessed January 15, 2009.

Wisconsin

From April 1997 to March 2004, Wisconsin implemented a *Smokeless States* ® project, partnering with the Tobacco-Free Wisconsin Coalition and the Smoke-Free Wisconsin to conduct statewide activities to reduce tobacco use, especially among

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1 American Lung Association. *2008 State Legislated Actions on Tobacco Issues Mid-Term Report,* www.lungusa.org

2 *Ibid.*

3 *American* Lung Association. *2008 State Legislated Actions on Tobacco Issues Mid-Term Report,* www.lungusa.org

Attachment 1

statehealthfacts.org
Your source for state health data

< Back to previous page

Public Place Smoking Bans in States, 2008

Table | Map | Map & Table

Rank by: State name (alphabetical)

Rank Order:

	Does the state have a public place smoking ban?	If yes, are any bars and restaurants exempt from the ban?	Are localities allowed to set more restrictive standards?
United States	35+ DC Yes	31+DC Yes	18 Yes
Alabama	Yes	Yes, bars, lounges, retail tobacco stores, and tobacco businesses	Yes
Alaska	Yes	Yes, all bars and restaurants with a seating capacity of under 50 persons	Not stated
Arizona	Yes	Yes, retail tobacco stores that are physically separated and independently ventilated	Yes
Arkansas	Yes	Yes, all restaurants and bars licensed by the State of Arkansas that prohibit at all times all persons less than twenty-one (21) years of age from entering the premises if secondhand smoke does not infiltrate into areas in which smoking is prohibited under this subchapter	Not stated
California	Yes	No	Not stated
Colorado	Yes	Yes, cigar-tobacco bars, airport smoking concession, casinos	Yes
Connecticut	Yes	Yes, tobacco bars and casinos.	Not stated
Delaware	Yes	No	Not stated
District of Columbia	Yes	Yes, tobacco bars and outdoor areas of restaurants, taverns, clubs, brew pubs, or nightclubs	N/A
Florida	Yes	Yes, stand-alone bars 1	No
Georgia	Yes	Yes, outdoor areas of places of employment, bars and restaurants to which access is denied to any person under the age of 18 and that do not employ any individual under the age of 18	Not stated
Hawaii	Yes	No	Yes
Idaho	Yes	Yes, bars	Yes
Illinois	Yes	Yes, bowling establishments and places whose primary business is the sale of alcoholic beverages for consumption on the premises	Yes
Indiana	No		Yes
Iowa	No		Not stated
Kansas	No		Yes
Kentucky	No		Not stated
Louisiana	Yes	Yes, bars, casinos, and outdoor patios	Yes
Maine	Yes	Yes, race tracks	Not stated
Maryland	Yes	Yes, retail tobacco stores, tobacco manufacturers, importers or wholesalers.	Yes, except for Charles and St Mary's counties
Massachusetts	Yes	Yes, smoking bars 2	Yes
Michigan	No		Not stated
Minnesota	Yes	Yes, tobacco products shops.	Not stated
Mississippi	No		Not stated
Missouri	No		Yes
Montana	Yes	Yes, until September 30, 2009, bars, provided that smoke from the bar does not infiltrate into areas where smoking is prohibited under this section	No
Nebraska	No		Not stated
Nevada	Yes	Yes, areas within casinos where loitering by minors is already prohibited by state law, stand-alone bars, taverns and saloons, and strip clubs	Yes
New Hampshire	Yes	Yes, social or fraternal organizations not open to the public.	Not stated
New Jersey	Yes	Yes, cigar bars and casinos	Yes
New Mexico	Yes	Yes, retail tobacco store, cigar bar, tobacco manufacturer, state licensed gaming facility, casino or bingo parlor.	Yes
New York	Yes	Yes, cigar bars and outdoor dining areas of food service establishments	Not stated
North Carolina	No		Allows local governments to prohibit smoking in buildings they own lease or occupy.
North Dakota	Yes	Yes, bars and outdoor areas	Yes
Ohio	Yes	Yes, outdoor patios	Not stated
Oklahoma	Yes	Yes, stand-alone bars, stand-alone taverns, gaming areas, and outdoor seating areas of restaurants	Not stated
Oregon	Yes	Yes, bars and restaurants that are posted as off-limits to minors	No
Pennsylvania	No		No
Rhode Island	Yes	Yes, Some gambling facilities, smoking bars, stand-alone bars, stand-alone taverns, gaming areas	Not stated

Attachment 2

Sorted By Tax Rate

State	Tax Rate (per pack of 20)
New York	$2.750
New Jersey	$2.575
Massachusetts	$2.510
Rhode Island	$2.460
Washington	$2.025
District of Columbia	$2.000
Michigan	$2.000
Connecticut	$2.000
Hawaii	$2.000
Maryland	$2.000
Maine	$2.000
Arizona	$2.000
Alaska	$2.000
Vermont	$1.990
Wisconsin	$1.770
Montana	$1.700
South Dakota	$1.530
Minnesota	$1.504
Texas	$1.410
Iowa	$1.360
Pennsylvania	$1.350
New Hampshire	$1.330
Ohio	$1.250
Oregon	$1.180
Delaware	$1.150
Oklahoma	$1.030
Indiana	$0.995
Illinois	$0.980
New Mexico	$0.910
California	$0.870
Colorado	$0.840
Nevada	$0.800
Kansas	$0.790
Utah	$0.695
Nebraska	$0.640
Tennessee	$0.620
Wyoming	$0.600
Arkansas	$0.590
Idaho	$0.570
West Virginia	$0.550
North Dakota	$0.440
Alabama	$0.425
Georgia	$0.370
Louisiana	$0.360
North Carolina	$0.350
Florida	$0.339
Kentucky	$0.300
Virginia	$0.300
Mississippi	$0.180
Missouri	$0.170
South Carolina	$0.070

	Fewer Kids Becoming Addicted Adults	Fewer Current Adult Smokers	Future Smoking Deaths Prevented	Future State Health Care Savings	Medicaid Share of Future Health Savings
Rhode Island	5,400	2,400	2,300	$117.3 million	$32.6 million
South Carolina	41,700	21,900	19,100	$937.8 million	$173.3 million
South Dakota	5,500	2,600	2,400	$121.0 million	$14.4 million
Tennessee	46,900	29,900	22,900	$1.1 billion	$238.5 million
Texas	151,200	73,900	67,900	$3.3 billion	$454.0 million
Utah	8,900	5,400	4,200	$207.1 million	$33.8 million
Vermont	3,100	1,600	1,400	$69.5 million	$13.8 million
Virginia	56,100	29,700	25,800	$1.2 billion	$153.2 million
Washington	30,100	14,600	13,500	$665.5 million	$118.4 million
West Virginia	16,900	10,500	8,100	$395.5 million	$95.6 million
Wisconsin	33,200	15,900	14,800	$732.1 million	$105.3 million
Wyoming	4,100	2,300	1,900	$93.6 million	$13.5 million
Total USA	***1,971,300***	***1,010,600***	***896,000***	***$44.0 billion***	***$7.4 billion***

These projections are based on research findings that a 10% cigarette price increase reduces youth smoking rates by 6.5%, adult rates by 2%, and total consumption by 4%. Kids stopped from becoming addicted adult smokers or from dying from smoking are from all kids alive today. Reduced adult deaths is from current adult smokers. Future healthcare savings accrue over the lifetimes of persons who stop smoking or never start because of the cigarette tax increase. Savings are in 2004 dollars. The Medicaid Share of Future Health Savings amounts for each state represent the future reductions to total healthcare expenditures by each state's Medicaid program.

Sources. Congressional Research Service, *Projected FY2008 Allotments Under Compromise Proposal, Compared to Allotment Projected Under Current-Law Baseline,* September 2007. Chaloupka, F, "Macro-Social Influences: Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products," *Nicotine & Tobacco Research*, 1999, and other price studies at http://tigger.uic.edu/~fjc and www.uic.edu/orgs/impacteen. Orzechowski & Walker, *Tax Burden on Tobacco*, 2006. USDA Economic Research Service, www.ers.usda.gov/Briefing/tobacco. Farrelly, M, et al., *State Cigarette Excise Taxes: Implications for Revenue and Tax Evasion*, RTI International, May, 2003. CDC, *Data Highlights 2006* [and underlying CDC data/estimates]. Hodgson, T, "Cigarette Smoking and Lifetime Medical Expenditures," *The Millbank Quarterly* 70(1), 1992. U.S. Census. National Center for Health Statistics. Miller, L. et al., "State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993," *Public Health Reports* 113: 140-151, March/April 1998; Orleans, CT, et al., "Helping Pregnant Smokers Quit: Meeting The Challenge in the Next Decade", *Tobacco Control* 9(Supplemental III): 6-11, 2000. For information on shorter-term healthcare savings, see Miller, P, et al., "Birth and First-Year Costs for Mothers and Infants Attributable to Maternal Smoking," *Nicotine & Tobacco Research* 3(1):25-35, February 2001. Lightwood, J & Glantz, S, "Short-Term Economic and Health Benefits of Smoking Cessation - Myocardial Infarction and Stroke," *Circulation* 96(4):1089-1096, August 19, 1997.

Campaign for Tobacco-Free Kids 01.08.09 / Eric Lindblom & Ann Boonn, January 12, 2009

Information on the benefits of increasing state tobacco taxes is available at http://www.tobaccofreekids.org/research/factsheets/index.php?CategoryID=18.

a clean indoor air public places ordinance. Behavioral Risk Factor Surveillance System (BRFSS) data from 2001-2005 were used to test whether smoking rates changed in Fayette County from the pre- to post-law period, relative to the change in 30 Kentucky counties with similar demographics. The sample consisted of 10,413 BRFSS respondents: 7,139 pre-law (40 months) and 3,274 post-law (20 months). Results of the study showed a 31.9 percent decline in adult smoking in Fayette County (25.7 percent pre-law to 17.5 percent post-law). In the group of 30 control counties, the rate was 28.4 percent pre-law and 27.6 percent post-law. There were an estimated 16,500 fewer smokers in Fayette County during post-law to pre-law. The authors conclude there was a significant effect of clean-indoor air legislation on adult smoking rates.

Khuder, S. A., Milz, S., Jordan, T., Price, J., Silvestri, K., & Butler P. (2007). The impact of a smoking ban on hospital admissions for coronary heart disease. Preventive Medicine, 45(1), 3-8. Retrieved January 13, 2009 from http://www.ncbi.nlm.nih.gov/pubmed/17482249.
The city of Bowling Green, Ohio implemented a clean indoor air ordinance banning smoking in workplaces and public places in March 2002. This study evaluates the effect of this ordinance on hospital admissions for smoking-related diseases. A reduction in admission rates for smoking-related diseases was achieved in Bowling Green compared to the control city. The largest reduction was for coronary heart disease, where rates were decreased significantly by 39 percent after one year and by 47 percent after three years following the implementation of the ordinance. The findings of the study suggest that clean indoor air ordinances lead to a reduction in hospital admissions for coronary heart disease, thus reducing health care costs.

Lee, D., Dietz, N., Arheart, K., Wilkinson, J., Clark III, J., & Caban-Martinez, A. (2008). Respiratory effects of secondhand smoke exposure among young adults residing in a "clean" indoor air state. Journal of Community Health, 33(3), 117-125. Retrieved January 13, 2009, from http://www.medscape.com/viewarticle/572987.
The prevalence of self-reported secondhand smoke (SHS) exposures and its association with respiratory symptoms was examined using a telephone survey sample (1,858) of young adults (ages 18-24) residing in Florida, a state with a partial clean indoor air law. Nearly two-thirds (64 percent) reported visiting a bar or nightclub which exposed them to SHS in the previous month; nearly half (46 percent) reported SHS exposure while riding in automobiles; 15 percent reported occupational SHS exposure; and nearly 9 percent reported living with at least one smoker. Personal smoking behavior, parental smoking history, and exposure to SHS in automobiles and in bars or nightclubs were significantly associated with increased reports of respiratory symptoms. Despite residing in a "clean" indoor air state, the majority surveyed continued to report exposure to SHS, especially in automobiles and in bars. These exposures adversely impact respiratory health. The authors conclude that all municipalities should pursue clean indoor air legislation which does not exempt bars and restaurants.

McCaffrey, M., Goodman, P. G., Kelleher, K., & Clancy L. (2006). Smoking, occupancy and staffing levels in a selection of Dublin pubs pre and post a national smoking ban, lessons for all. Irish Journal of Medical Science, 175(2) 37-40. Retrieved January 14, 2009 from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=16872027.
In March 2004, the Irish government introduced a comprehensive workplace smoking ban to protect the health of workers. This study evaluates the impact the ban had on staffing levels, customer numbers, and smoking rates in a sample of public houses in Dublin. A total of 38 public houses were visited prior to the introduction of the ban. Each visit lasted at least three hours, and the number of staff, customers and the number of people smoking was recorded each hour. Follow-up visits were conducted exactly one year later, on the same day of the week and at the same time of day, allowing control for seasonal and weekday effects. The results showed a decrease (8.82 percent) in average staff levels while customer numbers increased by 11 percent. There was a dramatic reduction in numbers smoking on a visit to a pub (77.8 percent). The authors conclude that while the hospitality industry predicted major job losses as a consequence of the introduction of the smoking ban, there was no significant decrease in the number of staff employed or in customer numbers.

Stolzenberg, L., & D'Alessio, S. J. (2007). Is nonsmoking dangerous to health of restaurants? The effect of California's indoor smoking ban on restaurant revenues. Evaluation Review, 31(1) 75-92. Retrieved on January 14, 2009 from http://www.ncbi.nlm.nih.gov/pubmed/17259576?dopt=Citation.
The state of California passed the Smoke-Free Workplace Act on January 1, 1995. Many restaurant owners, especially owners of restaurants that served alcohol, opposed the ban for fear that businesses would be affected adversely because of the loss of patrons who smoked. The authors assessed the effect of California's indoor smoking ban on revenue rates for all restaurants, for non-alcohol-serving restaurants, and for alcohol-serving restaurants. Results show that revenues for alcohol-serving restaurants dropped by about 4 percent immediately following the establishment of the indoor smoking ban. However, this reduction was temporary because revenues for alcohol-serving restaurants quickly returned to normal levels. Findings also revealed that the indoor smoking ban had little observable impact on the revenue rate for restaurants overall and for non-alcohol-serving restaurants.

Chairman Barnett

Senate Public Health and Welfare Committee Meeting

January 20, 2009

Agency Response to Follow Up Question
January 30, 2009

Public Health and Welfare
Date: 02/09/09
Attachment: 2

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
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Request from the Senate Public Health and Welfare Committee:
Agency response to 1-20-09 hearing question

1. How much does the KHPA pay for the wellness screening and initiatives?

    - For the Plan Year 2008 the health plan had expenses of $3.2 million for the wellness program administered by Health Dialog.
    - There are two KHPA staff members working full time on the wellness program with an annual salary cost of $98k.
    - The wellness program is provided to benefits eligible state and non sate employees who are enrolled in the state employee health plan or who have waived coverage in the plan. Retirees, spouses, and dependents 18 years or older who are enrolled in the state employee health plan are also eligible to participate.
    - Some of the 2008 program highlights are:

        a. 15,744 individuals completed the Personal Health Assessment

        b. 555 individuals participated in a coaching program (tobacco, weight management or stress)

        c. 5,089 individuals utilized the health coaching service

        d. 10,403 individuals were identified as having one or more chronic conditions of which 1,397 of these individuals were identified as high risk. All of these high risk individuals have been contacted by a health coach and provided educational materials.

    - For 2009 we have over 2,700 individuals participating in the tobacco cessation program.

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Fax: 785-296-6995

Jan Lunn - FW: Suggested Response to Senator Colyer

From: Cathy Harding <charding@kspca.org>
To: <jan.lunn@senate.ks.gov>
Date: 2/9/2009 9:13 AM
Subject: FW: Suggested Response to Senator Colyer

To: Senator Jim Barnett
Re: Response to Question raised by Senator Jeff Colyer
From: Cathy Harding, CEO, Kansas Association for the Medically Underserved
Date: January 26, 2009

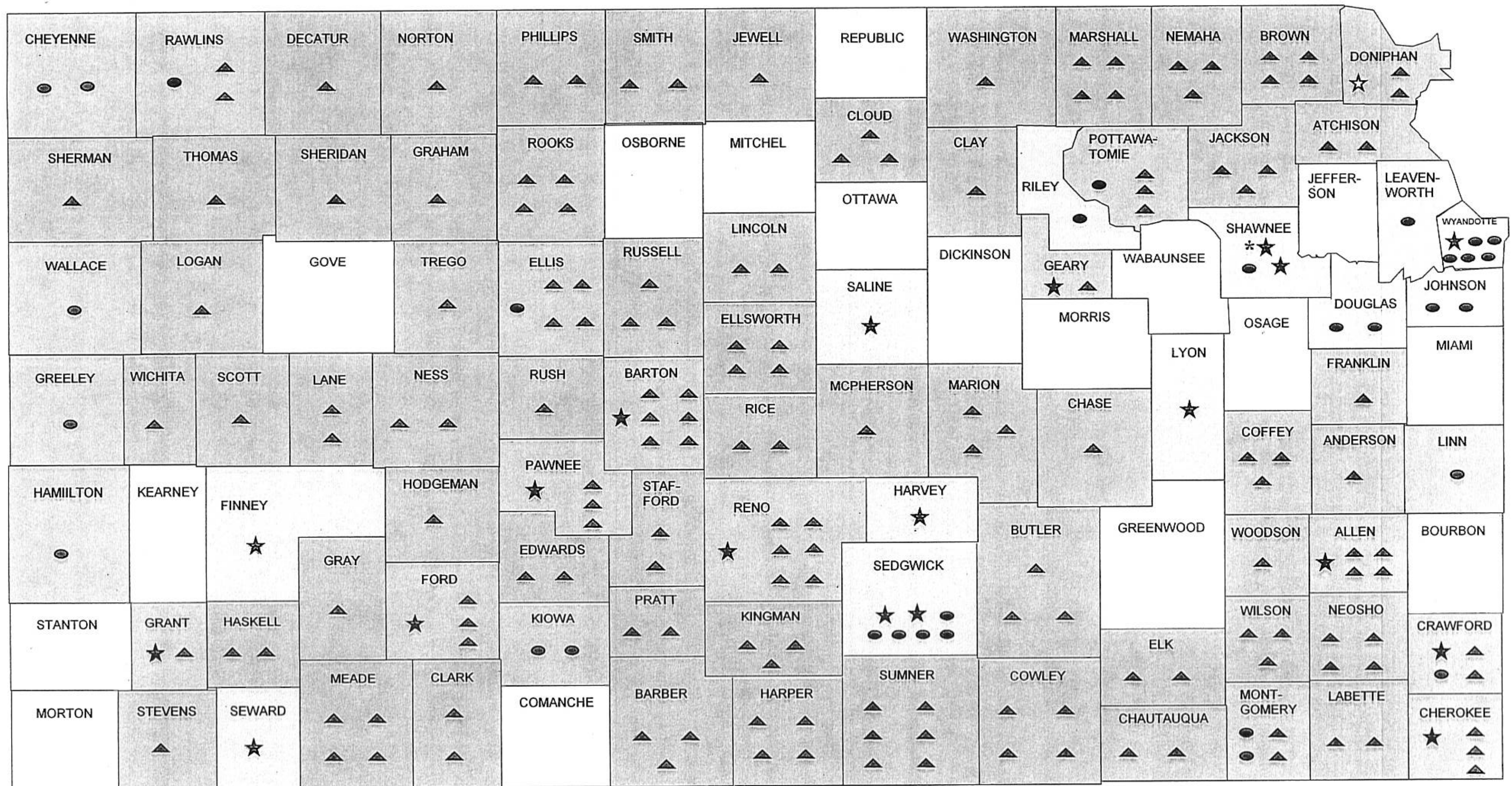
During Kansas Association for the Medically Underserved's testimony to the Senate Public Health and Welfare Committee on Wednesday, January 21, 2009, Senator Colyer asked Cathy Harding what was the Median/Mean Income in Kansas during the same time period that she was using in her presentation on Access to all Kansans.

Response: According to the U.S. Census, the per capita income for Kansas in 2007 was estimated at $25,197 and $26,688 for the United States. For the same time period, the Kansas median household income was $47,451 and $50,740 for the nation.

Thanks for your interest and the opportunity to present. Please let me know if you need anyl additional information.

Public Health and Welfare
Date: 02/09/09
Attachment: 3

State-Funded Primary Care and Rural Health Clinic Sites by County



Public Health and Welfare
Date: 02/09/09
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SFY 2009 State Funded Primary Care Clinic Sites by County

Allen: Community Health Center of Southeast Kansas* (Dental)
Barton: We Care Project*
Cherokee: Community Health Center of Southeast Kansas* (2 sites)
Cheyenne: Cheyenne County Hospital Clinics (2 sites)+
Crawford: Community Health Center of Southeast Kansas* (2 sites)
Mercy Health System+
Douglas: Health Care Access
Heartland Clinic
Ellis: First Care Clinic
Finney: United Methodist Mexican-American Ministries* (2 sites)
Ford: United Methodist Mexican-American Ministries*
Geary: Konza Prairie Community Health Center*
Grant: United Methodist Mexican-American Ministries*
Greeley: Greeley County Family Practice+
Hamilton: Hamilton County Family Practice+
Harvey: Health Ministries Clinic* (Look-Alike)
Johnson: Health Partnership Clinic of Johnson County (2 sites)
Mercy and Truth Medical Missions
Kiowa: Kiowa County Hospital Clinics (2 sites)+
Leavenworth: St. Vincent Clinic (Caritas)
Linn: Mercy Health System+
Lyon: Flint Hills Community Health Center*
Montgomery: Mercy Health System+
Montgomery County Community Clinic
Pawnee: We Care Project*
Pottawatomie: Community Health Ministry
Rawlins: Rawlins County Health Department
Reno: PrairieStar Community Health Center*
Riley: Riley County-Manhattan Health Department
Saline: Salina Family Healthcare* (2 sites)
Sedgwick: Center for Health and Wellness
E.C. Tyree Health and Dental Clinic
Good Samaritan Clinic
GraceMed Health and Dental Clinic* (4 sites)
Guadalupe Clinic
Healthy Options Clinic
Hunter Health Clinic* (5 sites)
Seward: United Methodist Mexican-American Ministries*
Shawnee: Marian Clinics
Shawnee County Health Agency* (3 sites)
Wallace: Wallace County Family Practice+
Wyandotte: Duchesne Clinic (Caritas)
Mercy and Truth Medical Missions (2 sites)
Silver City Health Center
Southwest Blvd. Family Health Care

* = FQHC   + = Rural Health Clinic

Number and Type of Rural Health Clinics By County (1-23-09)

There are 174 rural health clinics in Kansas.

Sixty-four of these clinics are free-standing.

The remaining 110 are provider based, affiliated with 65 facilities.

Allen—4 FS
Anderson—1 PB
Atchison—2 PB
Barber—3 PB
Barton—2 FS, 4PB
Brown—1 FS, 3PB
Butler—3 FS
Chase—1 FS
Chautauqua—2 PB
Cherokee—2 FS, 1PB
Cheyenne—2 PB
Clark—2 PB
Clay—1 FS
Cloud—2 FS, 1 PB
Coffey—3 PB
Cowley—3 FS, 1 PB
Crawford—1 FS, 2PB
Decatur—1 FS
Doniphan—2 PB
Edwards—2 PB
Elk—2 PB
Ellis—4 PB
Ellsworth—4 PB
Ford—1 FS, 2 PB
Franklin—1 FS
Geary—1 PB
Graham—1 PB
Grant—1 PB
Gray—1 PB
Greeley-1 PB
Greenwood—2 PB
Hamilton—1 PB
Harper—1 FS, 3 PB
Haskell—2 PB
Hodgeman—1 PB
Jackson—3 PB
Jewell—1 PB
Kingman—2 FS, 1 PB
Kiowa—2 PB
Labette—2 FS
Lane—1 FS, 1 PB
Lincoln—2 PB
Linn—1 PB
Logan—1 FS
Marion—3 FS
Marshall—4 PB
McPherson—1 FS
Meade—2 FS, 2 PB
Montgomery—2 FS, 1 PB
Nemaha—1 FS, 2 PB
Neosho—3 FS, 1 PB
Ness—2 PB
Norton—1 PB
Pawnee—2 FS, 1 PB
Phillips—2 PB
Pottawatomie—3 PB
Pratt—2 FS
Rawlins—2 PB
Reno—5 FS, 1 PB
Rice—2 FS
Rooks—3 FS, 1 PB
Rush—1 PB
Russell—3 PB
Scott—1 PB
Sheridan—1 PB
Sherman—1 PB
Smith—2 PB
Stafford—2 PB
Stevens—1 PB
Sumner—3 FS, 3 PB
Thomas—1PB
Trego—1 PB
Wallace—1PB
Washington—1 FS
Wichita—1 PB
Wilson—3 FS
Woodson—1 FS

FS=Free-Standing
PB=Provider-Based

A list of the Rural Health Clinics by County is available on the KDHE website at: http://www.kdheks.gov/bhfr/index.html

Heart Transplants

Chairman Barnett

Senate Public Health and Welfare

January 26, 2009

Agency Response to Follow Up Questions
January 28, 2009

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364

Public Health and Welfare
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**Request from the Senate Public Health and Welfare Committee:
Agency responses to 1-26-09 hearing questions**

1. How many heart transplants have there been done in the Kan Be Healthy programs?

   - From FY 2005-2008 KHPA had 7 KBH beneficiaries that had hospital claims for a heart transplant.

2. How many of those procedures paid across state lines?

   - All 7 of the beneficiaries received their heart transplant services out of state. Currently KHPA does not have any instate providers that perform pediatric heart transplants.

3. What are the reimbursement rates paid by Medicaid for Kan Be Healthy, are they negotiated?

   - Currently KHPA pays for heart transplants using 2 different methods (DRGs or Contract)

     A.) The DRG pays at 70% of billed charges.
     B.) The contract is a negotiated reimbursement rate that is usually a percentage of billed charges. Normally the negotiated rate is between 50-70% of billed charges.

4. Will the KHPA look at the issue of adult coverage for cardiac transplants and make a recommendation? Put the issue before the board?

   - This issue is currently under review.

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Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

5. What will the federal stimulus package do to us?

KHPA has closely examined the House version of the federal Medicaid stimulus proposal and concludes that Kansas would receive substantially more (about $200 million) from an across-the-board expansion of the Medicaid match rate (FMAP). Attached are several documents for further explanation.

Detailed explanation of current proposals as of 1-26-09

- **Senate** version of the stimulus package includes a provision that would extend Medicaid to families who become ineligible for the program because their incomes increase at a cost of $1.3 billion over 10 years;
- The **House** version would allow states to expand their Medicaid programs to low-income, recently unemployed workers through 2010 at a cost of almost $9 billion
- **Senate** version of the stimulus package includes federal subsidies for 65% of the health insurance premiums under COBRA for nine months,
- Compared with COBRA for one year under the **House** version
- **Senate** version of the stimulus package also does not include a provision for recently unemployed recently ages 55 and older or those with at least 10 years of tenure at their jobs to continue to receive health insurance through COBRA until they find a new job that offers coverage or reach age 65, when they can enroll in Medicare
- **House** version would allow
- **Senate** version of the stimulus package includes about $3 billion more for health care information technology than
- The **House** version, which includes $20 billion (Yoest, *Wall Street Journal*, 1/24)
- **Senate** version of the stimulus package the Department of Veterans Affairs would receive at least $3.4 billion for long-term care facilities, construction of new hospitals, and modernization of treatment centers;
- The **House** version would provide VA with at least $1 billion (Johnson, *CQ Today*, 1/23)
- **Senate** version of the stimulus package also includes $3.5 billion for research and facility renovations at NIH and $1.1 billion for research on the comparative effectiveness of medical treatments by the Agency for Healthcare Research and Quality (*CQ Today*, 1/24)

Update as of 1-28-09

Additionally, since the Senate Finance Committee met on Tuesday they approved a portion of the economic stimulus package over which the committee has jurisdiction that includes $18 billion for health care IT and funding to provide federal subsidies for health insurance under COBRA. In addition, the portion of the stimulus package approved by the committee includes $87 billion in additional federal Medicaid funds for states.

Prior to passage, the committee approved an amendment proposed by Sen. Jeff Bingaman (D-N.M.) under which states would receive 80% of the Medicaid funds as a flat rate increase and 20% based on their economic circumstances. The committee also approved an amendment proposed by Bingaman that would provide small states with additional funds under a Medicare program for hospitals that serve many low-income patients, as well as an amendment proposed by Sen. Jay Rockefeller (D-W.Va.) under which states would receive about $3.75 billion from Medicare for health care costs improperly covered by Medicaid (Wayne, *CQ Today*, 1/27).

2009 Federal Poverty Guidelines*

Federal Poverty Percentage	Household Size 1	2	3	4	5
30%	$ 3,249	$ 4,371	$ 5,493	$ 6,615	$ 7,737
37%	4,007	5,391	6,775	8,159	9,542
50%	5,415	7,285	9,155	11,025	12,895
75%	10,153	13,659	17,166	20,672	24,178
100%	10,830	14,570	18,310	22,050	25,790
125%	13,538	18,213	22,888	27,563	32,238
130%	14,079	18,941	23,803	28,665	33,527
133%	14,404	19,378	24,352	29,327	34,301
150%	16,245	21,855	27,465	33,075	38,685
185%	20,036	26,955	33,874	40,793	47,712
200%	21,660	29,140	36,620	44,100	51,580
225%	24,368	32,783	41,198	49,613	58,028
250%	27,075	36,425	45,775	55,125	64,475
300%	32,490	43,710	54,930	66,150	77,370

For each additional person in the household add $3,740 for 100% of FPL.

* from U.S. Department of Health and Human Services (www.aspe.hhs.gov). Figures are for the 48 contiguous states and D.C..

Note: The HHS poverty guidelines, or percentage mulitples of them (such as 125 percent etc.) are used as an eligibility criterion by a number of federal programs including Head Start, Food Stamps, National School Lunch Program, Low-Income Home Energy Assistance, Children's Health Insurance Program and some parts of the Medicaid program. In general, cash public assistance programs do not use these poverty guidelines in determining elibility. A more detailed list of programs that use or do not use these guidelines can be found at www.aspe.hhs.gov.

Public Health and Welfare
Date: 02/09/09
Attachment: 6

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on Senate Bill 62
Related to Prevention and Control of Tuberculosis
Plans for Postsecondary Educational Institutions

Presented to
Senate Public Health and Welfare Committee

By
Phil Griffin, Director of TB Prevention and Control
Kansas Department of Health and Environment

February 9, 2009

Chairman Barnett and members of the committee, I am Phil Griffin, Director of TB Prevention and Control at the Kansas Department of Health and Environment (KDHE) and I rise before you to speak in favor of Senate Bill 62.

As Senator Schmidt indicated when she presented this bill to the committee, the intent is to improve on language passed in K.S.A. 65-129e after we began working with stakeholders to assure regulations were both practical and feasible.

The intent of the statute and now the clarification sought in this bill is to prevent students who may have infectious Tuberculosis (TB) from entering the classroom and consequently infecting other students, staff and faculty. This would be prevented through a TB prevention and control plan developed by each postsecondary institution in the state with technical assistance offered by the TB Prevention and Control Program at KDHE. The plans will include a system for evaluating students at greatest risk of having TB prior to entering the classroom. KDHE would also have the responsibility for ongoing monitoring of compliance with the plans.

TB in the academic setting is of particular concern for multiple reasons. TB is transmitted from an infectious individual's lungs to those around them through bacilli expelled into the air. Physical contact with the infectious individual is not required for transmission; only contact with the air expelled by the infectious person is required. Because of the nature of the typical academic setting (dormitory living, communal dining, classroom settings, laboratory settings, etc.) many other people are potentially at risk when an individual is unidentified but infectious with TB.

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 540, TOPEKA, KS 66612-1368
Voice 785-296-0461 Fax 785-368-6368

Individuals with TB can be successfully treated. Individuals with TB who are being properly treated can and usually do carry on normal lives during treatment. They can attend classes and work without risking the health of those around them after two weeks of treatment in most cases.

This issue is of national concern and many other states are also struggling to pass legislation similar to this. I currently serve as President of the National TB Controllers Association and in that have been called upon by many states to advocate for changes in the overseas screening requirements for student visas as there are currently no requirements for TB screening of this population unlike those who are coming to the country under refugee status. It is unlikely that these requirements will be changed anytime soon at the national level. With this revision to the Kansas statute, we stand to have a model law that others are likely to consider as I have I already been asked for draft language by TB programs in Tennessee and Iowa as well as having been in conversation with some other states about our progress.

We are committed to continued work with the individual postsecondary institutions to assure that these actions are of minimum burden and that each of the unique institutional structures are prepared with best practice plans to prevent and control TB. We recognize that plans of this nature cannot be purely a one size fits all format as we must take into account the variety infrastructures we see and how these varied infrastructures manage the health and health protection needs within their systems.

Thank you for the opportunity to appear before the committee today. I will now stand for questions.

TESTIMONY
MICHAEL GIESSEL, MD

1. Ultraviolet irradiation is known to be the most prevalent and preventable, and preventable cause of skin cancers of all kinds.

2. Non-melanoma skin cancers (Basal and squamous cell) are most prevalent on chronically exposed areas of the body such as the face , forearms, and hands, suggesting chronic, cumulative exposure risk, whereas the most lethal form of skin cancer, melanoma, is found on areas of the body episodically over-exposed and poorly adapted to ultraviolet.exposure, such as the shoulders, back and lower legs.

3.Australian immigration studies reveal that 80% of the incurred risk of UV exposure occurs by the age of 18. This is a northern European gene pool transplanted to an equatorial environment , and immigration occurs at various ages allowing for analysis of age of exposure factors.

4. A Swedish study revealed that tanning bed usage increased the risk of **melanoma,** especially when exposure occurred at an early age.

5. A meta-analysis of seven studies found a significant increased risk of **melanoma and non-melanoma** skin cancers in indoor tanning bed users particularly if done before the age of 35. During my training in the 1970's, statistics for melanoma by anatomic site showed that males most commonly developed melanoma on the shoulders and upper back, while females had a disproportionate number of melanomas on the legs, reflecting the **natural sun tanning** habits of each gender. Now with the popularity of tanning booths, the most prevalent site for melanoma in females is the trunk.

6. A recently released report by the Surveillance, Epidemiology and End Results program conducted by the National Cancer Institute revealed that the occurrence of melanoma in women aged 15-39 increased by 50% in the years 1980-2004, whereas their male counterparts risk remained stable. This mirrors the fact that 70% of the tanning bed facility use is by women aged 16-29.

7. Vitamin D production by the skin is catalyzed by UVB, and not UVA, the spectrum allowed to be produced by tanning devices. Fifteen minutes of midday natural sun to a normally clothed body is sufficient to produce the vitamin D necessary for bone health. Vit D is easily provided by dietary measures in fortified milk and bread.

8. Tanning devices allow for exposure to huge amounts of UVA, not naturally available in nature for two reasons: Areas not normally available for public sun exposure are exposed in the privacy of a tanning bed, and these are areas not well adapted for that exposure; the presence of UVB (the sunburn spectrum) in nature limits

TESTIMONY - MICHAEL GIESSEL, MD

exposure time because painful sunburns occur if excessive time is spent. Tanning devices facilitate the exposure of vast amounts of UVA not available in natural settings.

9. Because the resultant injurious effects of tanning are delayed by so many years, youthful denial of the remote consequences is analogous to the tobacco issue. A bill to restrict youthful exposure would parallel our age related tobacco and alcohol regulations.

February 9, 2009

SB 101

Chairman Barnett and Committee members:

I am Darrell Ringler, Owner of the Midas Touch Golden Tans in Emporia, Kansas. I am here today to oppose SB 101 and share my concerns about the bill with the committee.

Indoor tanning facilities in Kansas are already regulated by the state Board of Cosmetology which requires that customers receive written warnings of the potential dangers of overexposure. The state requires a visible warning sign as well. Kansas businesses are also strictly regulated by the Food and Drug Administration under (21 CFR 1040.20). The regulations require another visible warning sign on each device, use of eyewear, maximum timer intervals specified by regulation and instructions to users to avoid or minimize injury.

Skin type is the major determinant regarding proper sun exposure in order to avoid sunburn. Each tanning device is equipped with a recommended exposure schedule. A knowledgeable, trained salon operator will factor in the these recommended exposure schedules, regardless of a client's age and never go over the maximum timer limit established by the Food and Drug Administration

In addition, all customer under the age of 16 must have a parental consent form signed and on file. This is to protect my business as well as my customer. I have attached a copy of the consent form to my testimony.

Given the state of our economic crisis, I would ask that the legislature would focus more on helping businesses grow than placing further burden and restrictions upon them. Thank you for your time and consideration of this issue.

Darrell Ringler
The Midas Touch Golden Tans
Emporia, Ks
620-344-2720 (cell)

Skin Type Analysis:

The Golden Rule of Smart Tanning is simple: Don't EVER sunburn!

1. **What is the natural color of your untanned skin?**
   - ☐ 0-Reddish-white
   - ☐ 2-White-beige
   - ☐ 4-Beige
   - ☐ 8-Light Brown
   - ☐ 12-Brown
   - ☐ 16-Black
2. **What is your natural hair color?**
   - ☐ 0-Red, light blond
   - ☐ 2-Blond, light brown
   - ☐ 4-Brown
   - ☐ 8-Dark Brown
   - ☐ 12-Brownish-Black
   - ☐ 16-Black
3. **What is your eye color?**
   - ☐ 0-Light Blue, Green, or Grey
   - ☐ 2-Blue, Green, Grey
   - ☐ 4-Light Brown
   - ☐ 8-Brown
   - ☐ 12-Dark Brown
   - ☐ 16-Black
4. **How many freckles do you naturally have on your untanned body?**
   - ☐ 0-Many
   - ☐ 2-Some
   - ☐ 4-Few
   - ☐ 8-None
5. **Which best describes your genetic heritage?**
   - ☐ 0-Celtic Caucasian
   - ☐ 2-Lignt-skinned European
   - ☐ 4-Dark-Skinned European
   - ☐ 8- Mediterranean
   - ☐ 12-Hispanic, Middle Eastern
   - ☐ 16- African, African-American
6. **Which best describes your SUNBURN potential?**
   - ☐ 0- Always burn without tanning.
   - ☐ 2- Usually burn but can tan.
   - ☐ 4- Occasionally burn but tan moderately.
   - ☐ 8- Seldom sunburn and tan easily.
   - ☐ 12- Rarely sunburn and tan profusely.
   - ☐ 16- Never Sunburn.
7. **Which best describes your TANNING potential?**
   - ☐ 0-Never tan
   - ☐ 2-Can tan lightly
   - ☐ 4-Can tan moderately
   - ☐ 8-Can get a dark tan

______**TOTAL** (add points to get your total score and identify your skin type)

Score	Skin Type	Description
0-7	Skin Type I	Very sensitive to sunlight
8-21	Skin Type II	Sensitive to sunlight
22-42	Skin Type III	Normal sensitivity to sunlight
43-68	Skin Type IV	Skin is tolerant of sunlight
69-84	Skin Type V	Skin is brown. Very tolerant.
85+	Skin Type VI	Skin is black. Extreme tolerance.

My skin type is:__________

(turn over)

9-8

Welcome to The Midas Touch Golden Tan

We are delighted that you've decided to share your tanning experience with u

Name:______________________ **Birthday:**__________

Address:______________________

City:______________ **State:**________ **Zip:**________

Telephone:______________ **Cell:**______________

Email:______________________

Referred By:______________________

Skin Type:______________**(see back)**

1. Have you taken any prescribed or over-the-counter medications recently? YES NC
   List any medications:______________________
2. Are you pregnant presently? YES NC
3. Are you under a doctor's care presently? YES NC
   If yes, please list any medical conditions______________
4. Have you ever been diagnosed with skin cancer: YES NC
5. Do you know how to wear protective eyewear? YES NC

****

PLEASE READ THE FOLLOWING CAREFULLY

A. Failure to use the eye protections provided to the customer by the tanning facility may result in damage to the eyes.
B. Overexposure to ultraviolet radiation causes burns.
C. Repeated exposure to ultraviolet radiation may result in premature aging of the skin and skin cancer.
D. Abnormal skin sensitivity or burning may be caused by reactions of ultraviolet radiation to certain foods, cosmetics, or medications, including: tranquilizers, diuretics, antibiotics, and high blood pressure medicines.
E. Any person taking a prescription or over-the-counter drug should consult a physician before using a tanning device. (Please see list of photosensitizing drugs on the front counter).

****

Prior to my initial exposure, I ______________, was given the opportunity to read the warning above. It was provided to me by the technician on duty at The Midas Touch Golden Tans. I fully understand, fully accept, and fully assume all risks associated with tanning.

______________________ ______________________
Signature of Consumer Date Signature of Technician Date

____
Signed Approval of Parent or Legal Guardian Date

714 SW Jackson, Suite 100
Topeka, KS 66603-3714
Phone: (785) 296-3155
Fax: (785) 296-3002
e-mail: kboc@kboc.state.ks.us
website: www.accesskansas.org/kboc

AD ASTRA PER ASPERA

KANSAS BOARD OF COSMETOLOGY

KATHLEEN SEBELIUS, GOVERNOR

Senate Committee on Public Health and Welfare
February 9, 2009

Testimony by Mary Lou Davis, Executive Director

Mr. Chairman and Members of the Committee:

In 1992 the legislature deemed it necessary that tanning facilities be regulated for the protection of the consuming public. At that time the Kansas Board of Cosmetology was given the regulatory authority to license and inspect tanning facilities.

Presently the Board licenses approximately 658 tanning facilities. Including tanning facilities, cosmetology profession facilities and body art facilities, the Board annually inspects over 4600 licensed facilities. This function is carried out by four full-time inspectors.

Senate Bill 101 prohibits a minor under the age of 14 from using a tanning device. The proposed legislation also requires that a minor, 14 years of age to 18 years of age, have parental or court appointed legal guardian written consent. The consent form is effective for one year, may be renewed annually and must be retained by the tanning facility for five years. Additionally this legislation specifies the Board "shall adopt rules and regulations" relative to the legislation.

During my tenure with the Board I recall several phone calls inquiring about limitations for minors seeking tanning services and only one complaint involving a minors use of a tanning device. I am aware that in the past several years there has been legislative action in other states attempting to set limits on minors seeking tanning services.

This past fall our agency was contacted by the Chair of the Department of Public Health Services at Wichita State University. Dr. Muma forwarded to our office a student research project entitled "Kansas Tanning Operators and their Support for Regulating Youth Access to Tanning." The study's underlying issue was health concerns due to overexposure to ultraviolet rays during teen years and the possible need for legislative action.

Due to the study, I contacted Dr. Muma and he was able to address the Board at their November meeting. There was open dialogue between Dr. Muma and the Board. Among several issues discussed was that overexposure to ultraviolet rays occurs with excessive time spent at the local swimming pool and likewise consumers subject themselves to health risk by seeking tanning services within a short span of time at a multitude of facilities.

After lengthy discussion, the Board took a neutral position regarding the need for legislation restricting minors access to tanning services.

As members of the committee may recall during the 2008 legislative session, the Board of Cosmetology introduced legislation that dealt with the cosmetology professions, the body art professions and tanning facilities. After resolving differences in conference committee, the legislation was enacted and became effective in July 2008.

One of the major provisions in that legislation was the ability to more effectively enforce the tanning laws and regulations. The Board had enforcement authority for cosmetology and body art; however, there were limited and costly options for enforcement regarding tanning facilities. With the statutory change the Board is now able to assess fines, "deny, refuse to renew, revoke, cancel, suspend or place on probation" a tanning facility license for violation of law and/or regulation.

The request for this statutory revision was due to a continued concern that facilities – a limited number – failed to comply with the law that a trained tanning device operator be present at all times the facility was in operation. Failure to have a trained operator places the consumer at a serious health risk. The operator must ensure the consumer uses the FDA required goggles, a skin type assessment is necessary to determine "tan time" and in general consumers must be advised of adverse risks associated with tanning and prescription and over-the counter drugs. Failure to have trained tanning device operators places the consumer at a serious health risk. Last year's statutory revision facilitates the Board's efforts to safeguard all consumers.

Due to the factors outlined by the Board during their November meeting and in view of last year's legislative revision to better safeguard the health of each consumer, the Board chose to remain neutral on this pending legislation.

As a side note - although I stated in the Board's fiscal impact statement submitted to the Division of the Budget that there would be minimal adverse impact on the agency budget with implementation of this legislation, the enforcement responsibility could potentially become a budget issue.

Senate Public Health and Welfare Committee
Senator Jim Barnett, Chairman

Testimony on SB 101
February 9, 2009

Anne Spiess
Legislative/Government Relations Director - Kansas
American Cancer Society

American Cancer Society Position Statement on Suntanning Facilities

The American Cancer Society is the nationwide community based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society set ambitious goals for significantly reducing the rates of cancer incidence and mortality along with dramatically improving the quality of life for all people with cancer. Meeting those goals requires a new partnership for the nation and will require a commitment from both the public and private sector.

Suntanning Facility Use during Teen Years and Twenties and Skin Cancer Risk

Skin cancer is the most common type of cancer in the United States, with melanoma as one of the most common cancers diagnosed among young adults. Ultraviolet (UV) radiation exposure from the sun is a known cause of skin cancer, and UV radiation exposure during childhood and adolescence increases the risk factor for a skin cancer diagnosis as an adult. While the scientific evidence concerning artificial UV radiation exposure, such as the use of suntanning facilities, among the general population is not clear, a new study published in the *International Journal of Cancer* found an increase in the risk for melanoma in people who first used suntanning facilities in their teen years and twenties[1]. The study was a literature review of 19 informative studies. The authors strongly suggested restrictions to the use of suntanning facilities to minors. In addition, the Centers for Disease Control and Prevention concluded that avoiding the use of suntanning facilities is an effective way to reduce exposure to UV radiation in their *Guidelines for School Health Programs: Preventing Skin Cancer Among Young People*.[2]

High Plains Division, Inc.
1315 SW Arrowhead Road Topeka, KS 66604-4020
785.273.4462 / 1.800.359.1025 f) 785.273.1503
Cancer Information 1.800.ACS.2345 www.cancer.org

Bright and Carpenter Consulting, Inc.
815 SW Topeka Blvd, Suite 2C, Topeka, KS 66612, (785) 783-7111, www.brightcarpenter.com

February 9, 2009

SB 101
Written Testimony
Before the Senate Public Health and Welfare Committee

Chairman Barnett and Members of the Committee;

I am Marlee Carpenter and I am here today to provide written testimony on behalf of the Indoor Tanning Association, provide information on the tanning industry in Kansas, and express concerns with SB 101.

The Indoor Tanning Association is a national trade association representing all major manufacturers, suppliers and distributors of indoor sun tanning equipment as well as professional sun tanning facilities nationwide.

State of Kansas Professional Indoor Tanning Facility Industry Statistics

- Total Number of Professional Indoor Tanning Facility Businesses.... **327**
- Total Employment at Professional Tanning Facilities **1,200**
- Total Professional Indoor Tanning Facility Customer Base **204,375**
- Total Annual Economic Impact of Indoor Tanning Facilities .... **$36.8 million**

Ownership: The majority of indoor tanning facilities have female ownership, as compared to 26.1 percent of businesses in all industries.

Regulation of the Indoor Tanning Industry – Indoor tanning facilities in Kansas are already regulated by the state Board of Cosmetology which requires that customers receive written warnings of the potential dangers of overexposure. The state requires a visible warning sign as well. Kansas businesses are also strictly regulated by the Food and Drug Administration under (21 CFR 1040.20). The regulations require another visible warning sign on each device, use of eyewear, maximum timer intervals specified by regulation and instructions to users to avoid or minimize injury. There are strict limits on the output of the equipment.

The FDA required warning sign on each device reads as follows:

Public Health and Welfare
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"DANGER Ultraviolet radiation. Follow instructions. Avoid overexposure. As with natural sunlight, overexposure can cause eye and skin injury and allergic reactions. Repeated exposure may cause premature aging of the skin and skin cancer. WEAR PROTECTIVE EYEWEAR; FAILURE TO MAY RESULT IN SEVERE BURNS OR LONG-TERM INJURY TO THE EYES. Medications or cosmetics may increase your sensitivity to the ultraviolet radiation. Consult physician before using sunlamp if you are using medications or have a history of skin problems or believe yourself especially sensitive to sunlight. If you do not tan in the sun, you are unlikely to tan from use of this product."

In addition, the FDA has spent a great deal of time and energy determining maximum exposure times thus making indoor tanning far less potentially harmful than exposure to the summer sun. Review of the complaints/injuries reported to the FDA in the years of 1993-2006 found a total of 49 injuries for the entire United States. During that 14 year period, there were an estimated 5.1 billion tanning sessions. That reflects an injury incidence rate of .000001%, or one reported injury per 100 million tanning sessions; an industry safety record of which we are proud.

Written Warning to Customers –When any customer comes to an indoor sun tanning facility, they are warned about the potential dangers of overexposure to ultraviolet light. The warning is conveyed by having each customer read and sign what we call an "informed consent" form. Most insurance carriers for tanning salons require the use of such a form. Further, giving clients an honest assessment of the potential benefits and risks associated with UV light exposure is the right thing to do. These forms play a key role in informing the customer about photo-sensitive drugs; the need for protective eyewear and confirm that the customer is 18 years or older. When the customer is a minor, a parent or guardian must sign.

Parental consent–is a standard practice for businesses in Kansas and across the US. If the individual is younger than 18, professional salons require that a consent form be signed by a parent or guardian. If the minor's parent doesn't approve, the minor would not be allowed to use the facility

Indoor Sun Tanning Prevents Dangerous Sunburn -- While repeated sunburn may contribute to skin problems later in life, the Indoor Tanning Association seeks to prevent the risks associated with sunburn. Professional tanning facilities work to manage exposure to ultraviolet light, based on the unique skin characteristics of each client, so that sunburn is avoided. As a result, the incidence of sunburn among those who use indoor tanning facilities is decreasing. Indoor tanners are up to 81 percent less likely to sunburn outdoors than those who do not use indoor tanning.

Benefits of exposure to UV Light –As more money is devoted to research on the benefits of UV light, all of us stand to gain from these scientific findings and the implications of such research. The benefit we know most about is Vitamin D. UV light striking your skin is the only way the body produces Vitamin D, a nutrient that is essential for good health.

The Indoor Tanning Industry believes that appropriate safeguards need to be in place but believe that SB 101 goes too far. The Indoor Tanning Industry encourages the committee to carefully consider SB 101 and the current safeguards in place.

Thank you for your time and please contact me if you have any questions.

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on SB 170 Interpreters Data Bank

Presented to
Public Health and Welfare

By
Cyndi Treaster, Director
Farmworker, Refugee and Immigrant Health
Kansas Dept of Health and Environment

February 9, 2009

Chairman Barnett and members of the committee, I am Cyndi Treaster and I am the director of the Farmworker, Refugee and Immigrant Health section at the Kansas Department of Health and Environment. I appreciate the opportunity to appear before you today to discuss Senate Bill 170. While we support the concept of an interpreter's data bank, there are some concerns that this bill raises.

Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S. C. 2000d, provides that no person shall "on the grounds of race, color, or national origin be excluded from participation, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." The Supreme Court, in Lau v. Nichols, 414 /U.S. 563 (1974) interpreted regulations by the predecessor to Health and Human Services, Dept of Health, Education and Welfare, to hold that Title VI prohibits conduct that has a disproportionate effect on Limited English Proficient (LEP) persons because such conduct constitutes national-origin discrimination. As a result, any entity that receives federal funds (i.e. Medicaid or Medicare payments or federal grants) must provide "meaningful access" to LEP individuals. This means that services must be provided in a language that LEP individuals understand through interpreters who transmit messages orally, and in some cases translators that transmit written information.

Health entities in Kansas are challenged by both these federal requirements to provide "meaningful access" as well as by the increase in foreign born Kansans,

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currently 6 percent of the population according to U.S. Census estimates. Among those Kansans five years and older, who speak a language other than English, 4.3 percent speak English less than very well. Identifying an interpreter for many hard to find languages (such as Karen, Burmese, Somali, etc.) and in rural areas, even more common languages like Spanish can be very difficult. When individuals who speak these languages along with English are indentified, many lack specific knowledge, skills and training that are necessary for effective interpretation. KDHE along with SRS have supported medical interpreting *Bridging the Gap* trainings, through contracts with Jewish Vocational Services, for several years in multiple areas of the state to teach this interpreting content. Fluency of language, critical in insuring accuracy, is not assessed as part of these trainings. We are aware of only two private companies that assess fluency, with limited languages, and this is by telephone.

In this bill an "available interpreter" voluntarily reports possessing the experience, skills or other qualifications to fulfill the role of interpreter. SB 170 directs KDHE to develop rules and regulations establishing standards for interpreters that would at a minimum include a code of ethics and *ensure* interpreters "provide translation that reflects precisely what is said by all parties". KDHE believes that to ensure that interpreters provide precise interpretation, a certification process to assess qualifications and assure fluency of medical interpreters would need to be established.

Though there have been some initial steps taken at the national level to develop such a certification, this is not likely to be developed in the near future. With support from the U.S. Office of Minority Health, the National Council on Interpreting in Health Care (NCIHC) in 2004 developed and published the *National Code of Ethics for Interpreters in Health Care*. In 2005, with the input of over 140 stakeholders, it developed and published *National Standards of Practice for Interpreters in Health Care*. These standards along with the NCIHC Code of Ethics are intended to provide the basis for discussion of the merits of a certification process to assess the qualification of interpreters working in health care settings. NCIHC has expressed concerns about a certification process articulated in the following NCIHC statement:

> Certification is a complex undertaking and NCIHC believes that the development of a national certification process goes beyond the creation of a test. Certification is a complex process in any field but especially in a field in which the content is steeped in difficult linguistic and cultural issues. While we wholeheartedly agree to the need for scientifically rigorous assessment methodologies, we still have much to learn about creating an equitable and fair process that will allow all competent interpreters, regardless of back ground, to be able to demonstrate the knowledge and skills they possess as interpreters, and that will not result in high numbers of good interpreters

failing simply because of a certification tool's inability to adequately assess knowledge and skills across cultural and linguistic differences.

In summary we believe if KDHE is to be truly helpful to health entities needing interpreters it will need to be able to verify the experience, skills and other qualifications needed to ensure effective communication. This should include a certification process that has not as yet been developed in Kansas or at the national level and may take several years to develop.

Thank you for the opportunity to appear before the committee today. I will now stand for questions.

Thomas L. Bell
President

TO: Senate Public Health and Welfare Committee

FROM: Chad Austin
Vice President, Government Relations

SUBJECT: Senate Bill 170

DATE: February 9, 2009

The Kansas Hospital Association appreciates the opportunity to provide comments on Senate Bill 170. The proposed legislation would require the Secretary of the Kansas Department of Health and Environment to establish a data bank of available interpreters and set standards for those interpreters.

The establishment of a voluntary data bank of language interpreters may make it easier for Kansas hospitals and other health care providers in locating such individuals. As the population of Kansas becomes more diverse, hospitals continue to take safeguards to avoid any communication barriers. These precautions include creating a list of community members, employees and outside organizations that may provide language interpreter services. Many hospitals have contracted with qualified organizations such as AT&T Language Line Services where an interpreter can be reached within seconds every day of the year. KHA supports the provision in Senate Bill 170 that does not require health care providers to use only those interpreters that are registered in the data bank. This provision may preclude hospitals from using those employees or other individuals that may not be included in the data bank but provide language assistance.

The Kansas Hospital Association supports the voluntary data bank outlined in Senate Bill 170. Thank you for your consideration of our comments.

Public Health and Welfare
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