Approved: 05/05/10
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:37 p.m. on March 15, 2010, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Amanda Nguyen, Kansas Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Pam Scott, Executive Director, Kansas Funeral Directors Association

Others attending:
See attached list.

Senator Barnett called attention to follow-up information furnished by the Kansas Health Policy Authority addressing Senator Schmidt's question on February 18 related to the American Pain Society Guidelines and follow-up which addresses SURS reports and issues discussed during the March 1 presentation. A chart on SFY 2009 expenditures on optional populations and spending is included (Attachment 1).

HB 2588 - Prepaid funeral plans; increase in amount of irrevocable funds

Renae Jefferies briefed those attending on **HB 2588** which amends current statute concerning the maximum irrevocable prepaid funeral agreement amount. The current agreement amount increases from $5,000 to $7,000 with successful passage of this legislation.

Pam Scott spoke in support of **HB 2588**. She indicated the prepaid funeral agreement amount will be increased from $5,000 to $7,000 plus the retail cost of a casket, urn and outside burial container. She indicated there had been no change to the funeral agreement amount for over five years. Ms. Scott provided statistics citing $6,195 as the average funeral cost in 2006. Ms. Scott further indicated that prepaid funeral agreements are exempt as countable assets when they are placed in a prepaid funeral agreement as an individual spends down assets to qualify for medical assistance (Attachment 2).

Questions from Senators were heard concerning whether this issue could be resolved with rules and regulations instead of legislation, whether interest is accrued on the pre-paid account, whether additional dollars could be added to an already established account, the average cost of cremation, whether there is a fee to manage the agreement, whether the prepaid agreement includes arrangement for a burial plot and whether there is consumer disclosure related to the funeral agreement.

Ms. Scott indicated rules and regulations could potentially be used (with the addition of a statutory monetary limit) rather than legislation; interest is accrued on a prepaid funeral agreement and is deposited into the account; increases can be contributed to an already established account; the cost of cremation was unknown to the conferee; typically there is no fee to manage a prepaid funeral agreement, however, in a trusted agreement, fees and expenses could be deducted; the prepaid agreement can include a burial plot; and prepaid funeral agreements would include consumer disclosure with the passage of **HB 2589**.

Senator Schmidt moved to pass out favorably **HB 2588**; Senator Kelsey seconded the motion. In discussion, Senators came to consensus that **HB 2589** should be heard prior to taking action on **HB 2588**. Senator Schmidt withdrew her motion; Senator Kelsey withdrew his second.

HB 2589 - Prepaid funeral arrangements; required disclosures

Minutes of the Senate Public Health and Welfare Committee at 1:37 p.m. on March 15, 2010, in Room 546-S of the Capitol.

Renae Jefferies briefed those attending on **HB 2589** which proposes enactment of two statutes regarding prearranged funeral agreements and defines the term "prearranged funeral agreement." The first section sets out disclosures that prearranged funeral agreements involve payment of money or the purchase or assignment of an insurance policy or an annuity must contain:

- names and addresses of seller and purchaser
- a statement of the funeral goods and services being purchased
- whether the contract is guaranteed or not; if it is guaranteed, the goods and services included are listed
- whether the agreement is revocable or irrevocable
- the disposition of any excess funds remaining after the goods and services are paid for

Section two of the legislation provides that if an agreement is funded by any means other than an insurance policy or annuity, the agreement shall contain disclosures as to:

- the bank, credit union, savings and loan or trustee of the funeral trust in which the funds are deposited
- a notice that reasonable fees and expenses may be deducted from the trust

Senator Kelly inquired whether the term "reasonable fees and expenses. . . " had been defined in the statute. Ms. Jefferies clarified the bill contained no definition of "reasonable fees and expenses."

Pam Scott provided testimony (Attachment 3) supporting this legislation which was requested by the Kansas Funeral Directors Association in response to study results conducted by the National Funeral Directors Association concerning prearranged funeral agreements. The study involved review of state laws concerning trusting requirements, portability of pre-need contracts, and consumer pre-need contract disclosures. The study results rated Kansas laws as poor because Kansas statutes do not mandate disclosures. Ms. Scott indicated this law would protect the consumer and the funeral home to ensure clarity related to agreement terms and good/services provided in a prearranged funeral agreement.

Upon a motion by Senator Kelsey and a second by Senator Huntington to pass out favorably **HB 2588**; the motion passed unanimously.

Upon a motion by Senator Colyer and a second by Senator Brungardt to recommend favorable passage of **HB 2589**; the motion carried.

SB 506 - Crematory operators, licensure, fees

Chairman Barnett outlined to those attending the events surrounding this legislation. **SB 506** (as amended) was passed out of Public Health and Welfare on February 16, 2010. At that time, it was recognized the effective dates for the rules and regulations conflicted with the effective date of the Act. Therefore, the committee report was not submitted to the Committee of the Whole, and the bill remained in the Public Health and Welfare Committee.

Ms. Folmsbee distributed a balloon amendment for review by Senators that would correct the inadvertent conflict. Following review of the amendments proposed, Senator Schmidt, who voted on the prevailing side, moved to reconsider action on **SB 506**; Senator Huntington seconded the motion. The motion carried.

Senator Haley noted in the original deliberations the word "funeral" on page 9, line 17 was to have been struck. In the balloon, the word "funeral" was included. He requested clarification from Ms. Folmsbee who affirmed that a further technical amendment to the balloon would be required.

Upon a motion by Senator Schmidt and a second by Senator Huntington to adopt the amendments discussed (balloon and technical) and to pass out favorably **SB 506** (as amended), the motion carried.

The meeting adjourned at 2:30 p.m.

Sign-In Sheet

Senate Public Health & Welfare Committee
March 15, 2010

NAME	REPRESENTING
Patrick Vogelsberg	Kearney & Assoc.
Mack Smith	KS St Bd of Mortuary Arts
Pam Scott	Ks Funeral Directors Assn
Bill Snead	KFDA
Michelle Bittles	Cap. Strategies
Marlee Carpenter	KAHP
Sara Haworth	Intern – Sen. Vicki Schmidt

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KANSAS HEALTH POLICY AUTHORITY

February 18, 2010

Chairman Barnett,

Below is our agency response to the questions that were posed during the February 3, 2010 meeting of the Senate Public Health and Welfare Committee. Please let me know if there are any further questions.

1. Provide comparisons for FDA guidelines, Pain Society guidelines, and what we do

   FDA guidance on the maximum daily dose for about 1,200 pharmaceuticals is compiled in a database and available at http://www.epa.gov/ncct/dsstox/sdf_fdamdd.html#Description . Several limitations are noted with the publication, for example that when separate maximum recommended therapeutic doses (MRTD)s were reported for different routes of exposure, only the oral MRTD was included in the database, some pharmaceuticals have different MRTD values for male and female adults, children, or elderly patients and in this situation only MRTD values for the average adult patient were reported. In addition to these limitations, it should be noted that pure opioid analgesics have no ceiling dose for pain control. Appropriate dosages can vary widely depending on the duration of opioid use and the vulnerability of the individual to opioid side effects, such as respiratory depression.

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

State Self Insurance Fund:

Comparison of FDA Recommendations, American Pain Society Recommendations, and Current/Proposed DUR Board Limitations for Oral Opiod Analgesics (Facts and Comparisons® Classification)

Medication	FDA Maximum Recommended Daily Dose (FDA MRDD)[1] for a 60kg adult	Monthly equivalent	Journal of Pain High-Dose Recommendation (morphine equivalents)[2]	Monthly equivalent	Current limitations (mg/month)	Proposed limitations (mg/month)
hydrocodone	45	1350	200	6000	1350 (hyd/ibu)[3]	6000
oxycodone	319.8	9594	133	3990	14000 (L.A.)[4]	3990
hydromorphone	24	720	50	1500	1440	1500
meperidine	15	450	2,000	60000	36,000	
tramadol	6.67	200.1	6,000	180000	12,000	
propoxyphene	6.5	195	1,200	36000	11,700	
codeine	360	10800	1333	39990		39990
morphine sulfate	100.2	3006	200	6000		6000
oxymorphone	9	270	67	2010		2010
levorphanol	9	270	26.7	801		
methadone[5]	30	900	26	780		
tapentadol[6]						

[1]FDA MMD website - http://www.epa.gov/ncct/dsstox/sdf_fdamdd.html#Description

[2]American Pain Society Guidelines. High-dose defined as greater than 200mg morphine equivalents. The Journal of Pain, Vol 10, No 2 (February), 2009: pp 113-130

[3]1350mg limitation currently in place on hydocodone/ibuprofen combination products only

[4]14,400mg/month limitation currently on Oxycontin (long-acting oxycodone) only

[5]January 2010 DUR Board recommendation was to place no limitations on methadone

[6]Tapentadol (Nucynta) FDA approval in November 2008 - not yet available in dosing charts

2. Why is the number of pharmacies and providers reviewed by SURS set at 3 or more?
Examination of current SURS report thresholds confirms that the use "3 or more" rather than "more than 3" pharmacies or physicians will appear on a report. This threshold was set at 3 or more to decrease the likelihood of false positives on the report caused by legitimate uses of two pharmacies or prescribers such as multiple physicians in one practice groups, mid-level practitioners under the primary care physician, prescription filling at a secondary pharmacy if primary pharmacy is closed, etc. However we are able to modify these thresholds if needed. Please let us know if you would like us to examine lowering the pharmacy or physician threshold to 2 or more

3. How do we handle Hospice Prescriptions?

Medicaid Policy states that services, including medications, "related to the terminal diagnosis" are paid directly to the hospice provider through specific codes. Each code pays for a bundle of services, for example routine home care and respite care. Pain control is a fundamental part of these bundles of services for hospice care, and therefore utilization of controlled substances in hospice is neither individually reimbursed nor specifically tracked. The use of medications in hospice was examined in Chapter 6: Hospice Services as part of the 2008 Medicaid Transformation (see page 7 of the linked document: http://www.khpa.ks.gov/medicaid_transformation/download/2008/Chapter%206%20-%20Hospice%20Services.pdf). The program review identified narcotic utilization as an area to be examined closer because of the presence of claims outside the hospice provider for narcotic analgesics, however this was thought to be due primarily to beneficiaries obtaining retroactive eligibility for hospice.

4. Is the 10% reduction applied to DSH, LEAs and other supplemental payments?

The 10% reduction in payments is applied to DSH, LEAs and other supplemental payments.

5. Are FQHCs considered optional services?

Our previously submitted optional service list had some incorrect information. FQHCs are not considered an optional service. Attached is a corrected version of our optional service list.

Sincerely,

Andy Allison
Executive Director
Kansas Health Policy Authority

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KANSAS HEALTH POLICY AUTHORITY

March 4, 2010
Senator Jim Barnett
Chair Senate Public Health and Welfare

Senator Barnett,

In response to the questions posed by your committee that we needed to follow up on we have the following answers. Please let me know if you have any further questions.

1. Are there any SURS reports concentrating on narcotics only?

   There are reports that focus on narcotics only, or that could be focused on any other particular drug class. They operate by comparing all the beneficiaries in a peer group and identifying those that fall outside of service dollar "norms." The report is adjusted for age, sex, and morbidity. The reports can be based on pharmacy utilization, physician utilization, or other measures.

2. Has KHPA thought about extending the Multiple Pharmacies and Multiple Prescribers Reports for greater than a one month period?

   Additional historical information was obtained on the multiple pharmacy and multiple prescriber report from the SURS unit. These reports were originally set to pull 6 months of data. They found that many beneficiaries moved, changed providers, or saw specialists in that period of time. As a result there were many false positives, who had legitimate reasons for this behavior, that the SURS unit would spend time reviewing, only to find no problems. The time frame was reduced to 3 months, which decreased the number of false positives, but there were still several hundred individuals identified on each run, which was more than was able to be reviewed by the SURS unit staff. Therefore, the reports were altered to run over a monthly time frame, which has allowed for a manageable quantity of beneficiaries to review while still catching those who are most likely to be abusing their medical benefits (for example, seeing their primary care physician and going to the ER for additional pain medication in the same month). Please note that these reports are only one of the mechanisms by which beneficiaries are identified for review. In addition to other reports, a large number beneficiaries identified for review come from provider referrals.

3. Provide updated Optional Spending in Kansas Medicaid information.

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Fax: 785-368-7180

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

See Attached.

4. Are there any waivers or options of any combinations of those available for the state to draw down more federal dollars?

There are other options that would allow the state to draw down additional federal funds. Home and Community Based Service waivers are the best example of a program that allows us to expand services and draw down more federal dollars. However, these federal dollars must be matched with new state dollars, so there isn't any direct savings to the state (except to the extent that institutional care is avoided). Expanding other optional services, or adding optional populations, would also leverage additional federal funds. However, these expansions would also require additional state dollars. Under Section 1115 of the Social Security Act, states can ask that the Secretary of Health and Human Services waive any Federal Medicaid requirement, but we are not aware of any unused options at this time that are likely to be approved by CMS and that would generate significant savings for the state.

It is difficult to find options for drawing down additional federal dollars without also increasing state spending. One example is a federal grant, such as the $40 million grant KHPA recently received to build a new eligibility system and leverage community outreach for participation in Medicaid and CHIP. Most health care-related provider tax programs are also designed to leverage additional federal dollars. Examples include the proposed nursing facility tax, the existing hospital assessment program, and the recent extension of the HMO privilege fee to Medicaid managed care organizations. KHPA is not aware of additional provider tax options that would raise significant revenue.

Another example of a method states have used to generate additional federal dollars is to bring a pre-existing state-only activity into the Medicaid program. This is very common, and we can point to a number of examples in Kansas just in the last few years. We're not aware of any additional opportunities at this time.

5. Provide a report for the supplemental rebates that are generated when a drug class is brought into the preferred drug list (PDL).

In SFY2009, $3,853,613.18 was collected in supplemental rebates. These are the rebates negotiated directly by the KHPA Pharmacy Staff for drugs on our preferred drug list, and are in addition to the rebates mandated by CMS.

DRAFT - subject to change

1-6

Detailed Estimates of Optional Spending in Medicaid

Spending on Optional Services -- SFY 2009 (all agencies: SRS, KDOA, KHPA)

Adult Optional Services Description	CMC COS	Comments	FY 2009 Expenditures SGF	All Funds
Ambulatory Surg Ctr	CMS COS 101		483,745	1,109,048
Maternity Center	CMS COS 102		5,911	16,750
Pharmacy	CMS COS 071		40,449,057	109,647,757
Vision	CMS COS 092, 372, 379		465,357	1,313,268
Dental	CMS COS 081, 082		756,682	2,326,822
Local Health Dept	CMS COS 103,104, 105, 376		126,167	388,327
Attendant Care for Indepent. Living	CMS COS 231		39,256	39,256
Hospice	CMS COS 261		8,969,567	25,273,505
CMHC	CMS COS 293		391,370	1,120,442
Psychologist	CMS COS 094		7,390	21,157
Chiropractor	CMS COS 091		26	74
Podiatrist	CMS COS 093		8,955	25,139
Hearing Services	CMS COS 371, 378		123,049	340,196
Equip,Supplies,Orthotics/Pros.	CMS COS 373		3,729,204	10,313,065
Alcohol/Drug Treatment	CMS COS 294		10,587	30,308
Dietitian	CMS COS 297		0	0
Head Start	CMS COS 298		0	0
Physicial Therapist	CMS COS 299		163,204	409,341
Head injured rehab facility	CMS COS 193		2,960,527	8,475,601
Local Education Agencies	CMS COS 295		61	180
Target Case Management MRDD	CMS COS 241		5,065,119	14,500,770
TCM Frail Elderly	CMS COS 242		1,776,053	5,021,735
TCM TBI,PD,MH	CMS COS 243,244,245		1,836,300	5,257,086
Mg Care (HW)*	CMS COS 181		7,294,520	22,004,586
Mental Health Managed Care (PAHP)			20,820,447	59,606,204
Substance Abuse Managed Care (PIHP)			3,603,004	10,314,928
PCCM Case Mgmt	CMS COS 251 Mgd Care		88,374	244,126
Nursing Facility MH	CMS COS 025,022		1,169,723	3,348,763
ICF/MR	CMS COS 041,042		4,932,119	14,120,008
HCBS (SRS)	COS 191,193,194,195,196,197,198		171,642,697	491,390,488
HCBS (KDOA)			25,119,012	71,981,465
State Psych Hospital	CMS COS 021,024		351,458	1,006,179
State ICF-MRs	CMS COS 041		10,816,029	30,964,869
Total Optional Services			313,204,970	890,611,443

Summary**			SGF	All Funds
Optional Services			313,205,000	890,611,400
Optional Populations			426,866,800	982,357,200
Less Crossover			175,433,545	432,834,490
Total Optional Medicaid Spending			564,638,255	1,440,134,110
Total Medicaid Spending (excludes administration)				2,524,450,000
Percent Optional				57%

Most options will require statutory, regulatory, or policy changes, which will increase the time to implement

Some service changes, if large enough, or if impacted by significant rate changes, may also impact managed care rates. Only the known optional portion of managed care is included here.
SFY09 data is for a full year. Estimates for potential budget cuts for a portion of this year would need to be prorated.

*Total growth for 2009 and 2010 are consistent with KHPA Caseload total growth (6% per year).
Estimates differ from KHPA caseload estimates in the following ways:
Services for children, and transportation are mandatory.
**Summary numbers are rounded to the nearest hundred
SRS does not have data which splits according to optional populations
SGF adjusted downward because of ARRA
Medikan NOT adjusted for 18 month limit.
Removed from previous versions: transportation because it is a manadatory service; CDDO's
Totals (compared to optional Categories) from the MAR report (point-prevalent)
Mental Health services previously reported separately before; e.g., behavior management, MH
KHPA
SRS
KDOA

Detailed Estimates

Spending on Optional Ser

Spending on Optional Populations -- SFY 2009 Expenditures

Adult Optional Services Description	Medikan		Working Healthy		Breast and Cervical Cancer		Medically Needy Aged		Medically Needy Disabled		Medically Needy Families		ADAP		TB		FC aging out		SCHIP	
	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds
Ambulatory Surg Ctr	91,577	91,577	1,618	3,935	4,179	14,810	31,719	72,293	92,744	214,719	2,170	5,416	-	-	-	-	-	-	-	-
Maternity Center	-	-		-	-	-	-	-	3,356	7,770	-	-	-	-	-	-	-	-	-	-
Pharmacy	5,588,470	5,588,470	203,540	508,849	120,317	426,386	938,661	2,139,367	4,055,711	9,389,748	63,364	158,145	77,443	8,538,590	-		8,275	20,831	-	-
Vision	5,172	5,172	6,362	19,701	1,625	5,758	47,583	108,450	77,847	180,232	2,739	6,837	0	0	0	0	128	323	0	0
Dental	341	341	4,815	25,391	1,099	3,893	79,643	181,521	151,373	350,457	3,098	7,732	0	0	0	0	593	1,493	0	0
Local Health Dept	15,403	15,403	366	2,021	2,399	8,503	2,000	4,559	13,548	31,365	3,727	9,301	0	0	0	0	344	866	0	0
Attendant Care for Indepent. Living	525	525	0	195	-	-	165	375	5,548	12,845	0	-	0	0	0	0	0	-	0	0
Hospice	29,801	29,801	1,047	2,790	6,578	23,310	8,300,483	18,918,214	1,066,299	2,468,687	0	-	0	0	0	0	0	-	0	0
CMHC	70,247	70,247	(3,684)	(9,210)	-	-	-2,788	(6,354)		(317,666)		-						-		
Psychologist	771	771	34	86	-		6,827	15,559	5,782	13,387										
Chiropractor	-	-	-	-	-	-	0	-	12	29	0	-	0	0	0	0	0	-	0	0
Podiatrist	-	-	52	185	-	-	3,597	8,198	2,358	5,459		-						-		
Hearing Services	9,961	9,961	1,170	2,783	173	614	67,470	153,776	18,626	43,123	12	31						-		
Equip,Supplies,Orthotics/Pros.	277,174	277,174	21,068	59,033	2,760	9,782	349,160	795,795	775,105	1,794,516	4,881	12,183						-		
Alcohol/Drug Treatment			-		-		474	1,080	4,247	9,832	0									
Dietitian	-	-	-	-	-	-	0	-	0	-	0	-						-		
Head Start	-	-	-	-	-	-	0	-	0	-	0	-						-		
Physicial Therapist	33,864	33,864	506	3,290	125	443	2,945	6,712	27,620	63,947	52	130					931	2,343		
Head injured rehab facility	-		-		-		1,995,845	4,548,870	2,181,192	5,049,878	0									
Local Education Agencies	-	-	-	-	-	-	0	-	58	135	0	-						-		
Target Case Management MRDD	-		89,438	223,594	-		173,571	395,597	2,080,063	4,815,744	0									
TCM Frail Elderly	-		-		-		1,758,292	4,971,518	17,761	50,217	0									
TCM TBI,PD,MH	6,797	6,797	2,897	7,243	-		1,089,909	2,484,088	106,259	246,009	0									
Mg Care (HW)*	6,454,769	6,454,769	1,328,988	3,322,469	11,888	42,131	2,470,817	5,631,413	2,902,283	6,719,341	55,776	139,207	0	0	0	0	750,275	1,888,732	499	1,770
Mental Health Managed Care (PAH																				
Substance Abuse Managed Care (I																				
PCCM Case Mgmt	41,468	41,468	-		-		0				0									
Nursing Facility MH	7,202	7,202	10,020	25,049	-		1,045,834	2,383,633	0		0									
ICF/MR	-		-		-		588,395	1,341,052	4,159,020	9,628,929	0									
HCBS (SRS)	-		12,276	30,691	-		27,980,960	63,773,372	69,379,532	160,626,913	36	90					13,646	34,353		
HCBS (KDOA)							25,119,012	71,981,465												
State Psych Hospital	-	-	-	-	-	-	359,458	819,285	0	-	0	-	0	0	0	0	0	-	0	0
State ICF-MRs	-	-	-	-	-	-	421,360	960,352	0	21,456,118	0	-	0	0	0	0	22,621	56,946	0	0
Total Optional Services	12,633,542	12,633,542	1,680,513	4,228,097	151,144	535,631	72,831,390	181,690,167	87,126,344	222,861,734	135,855	339,072	77,443	8,538,590	0	0	796,813	2,005,887	499	1,770
Mandatory service costs	11,756,057	11,756,057	1,944,898	4,718,853	847,607	3,003,792	119,185,597	255,949,233	96,204,673	201,584,702	2,412,809	6,021,968	418	46,041	137,728	137,728	807,113	2,031,815	18,136,346	64,272,493
Total for Optional Populations	24,389,599	24,389,599	3,625,411	8,946,950	998,751	3,539,423	192,016,987	437,639,400	183,331,017	424,446,436	2,548,664	6,361,040	77,861	8,584,631	137,728	137,728	1,603,926	4,037,702	18,136,845	64,274,263

Summary**

Optional Services
Optional Populations
Less Crossover
Total Optional Medicaid Spending
Total Medicaid Spending (excludes administration)
Percent Optional

Most options will require statuto

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Medikan NOT adjusted for 18 mont
Removed from previous versions:
Totals (compared to optional Categ
Mental Health services previously

KHPA
SRS
KDOA

KANSAS FUNERAL DIRECTORS ASSOCIATION
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March 15, 2010

To: Senate Public Health and Welfare Committee

From: Pam Scott, Executive Director
Kansas Funeral Directors Association

Re: House Bill No. 2588

Chairman Barnett and members of the Committee, I appear before you today on behalf of the Kansas Funeral Directors Association (KFDA) in support of House Bill No. 2588. The KFDA represents over 300 funeral homes across the state of Kansas.

House Bill No. 2588 was introduced at the request of the KFDA. The bill would amend K.S.A. 16-303 to increase the dollar amount of funds that can be placed in an irrevocable funeral agreement, contract or plan from $5000 to $7000 plus the retail price of a casket, urn and outside burial container. This dollar amount has not increased for over 5 years.

The KFDA is requesting this increase because $5000 is not sufficient when considering today's funeral costs. The $5000 has not been increased since 2004. Statistics released by Federated Funeral Directors of America for 2008 show the average selling price of a "Regular Adult Funeral" nationwide as $6199.01. This amount does not include the outside burial container, cemetery expenses, additional travel expenses or cash advance items. Cash advance items include items such as flowers, the cost of death certificates, hair dressers, and clergy honorarium. The average gross sale reported was $8338.87. A National Funeral Directors Association 2007 General Price Survey found the average cost of an adult funeral in 2006 was $6,195.

We do not believe the increase contained in this bill will have any adverse fiscal impact on the state of Kansas. In fact it could have a favorable fiscal impact. Individuals going on medical assistance are encouraged to place funds into prearranged funeral agreements when spending down their assets to qualify for assistance. Such agreements are exempt as countable assets. The placing of funds in a prearranged funeral account has the effect of reducing the number of individuals that request funds under the funeral assistance program. Additionally, any funds remaining in a prearranged funeral account, after the payment of funeral expenses, are paid to the Estate Recovery Unit of the Kansas Department of Social and Rehabilitation Services, to the extent of medical assistance that has been expended on the deceased.

The KFDA would appreciate your support of House Bill No. 2588. I would be happy to respond to any questions you may have. Thank you.

Senate Public Health & Welfare
Date: 03/15/10
Attachment: 2

KANSAS FUNERAL DIRECTORS ASSOCIATION
1200 S. Kansas Avenue Topeka, KS 66612
785-232-7789 Fax 785-232-7791 www.ksfda.org

March 15, 2010

To: Senate Public Health and Welfare Committee

From: Pam Scott, Executive Director
Kansas Funeral Directors Association

Re: House Bill No. 2589

Chairman Barnett and members of the committee, I appear before you today in support of House Bill No. 2589 which was introduced at the request of our association.

The KFDA requested this bill in reaction to the results of a study the National Funeral Directors Association conducted on state prearranged funeral agreement laws. The NFDA General Counsel reviewed state laws looking at such things as trusting requirements, portability of preneed contracts and consumer preneed contract disclosures. The results of the study rated Kansas laws as poor because Kansas statutes do not mandate that disclosures, such as those set forth in this bill, be included in prearranged funeral agreements. If such disclosures were required in Kansas law, our laws would have received a "good" rating according to the NFDA. The KFDA has always believed Kansas has strong consumer oriented prearranged funeral agreement laws especially with the 100% trusting requirements we have in this state. We want to assure they are even stronger to protect the public.

The disclosures required by this bill should already be in most prearranged funeral agreements written in this state. They protect the consumer as well as the funeral home to make sure there is no doubt as to the terms of the agreements and what goods and merchandise are provided. The disclosures required are as simple as:

1. the names and addresses of the seller and the purchaser;
2. a statement of the funeral goods and services being purchased;
3. whether the contract is guaranteed or not guaranteed and if it is guaranteed; the goods and services included in the guarantee;
4. whether the contract is revocable or irrevocable;
5. what happens to excess funds remaining after the funeral goods and services have been paid for;
6. a statement that the seller may substitute goods of equal quality, value and workmanship if those specified in the funeral agreement are not available at time of need;

7. the name of the bank, credit union, or savings and loan, or the trustee of the funeral trust the funds are deposited in;
8. a notice that reasonable fees and expenses may be deducted from the trust; and
9. a requirement that the financial institution in which the funds are placed provide written notification to the purchaser that funds for the prearranged funeral agreement have been deposited.

The prearranged funeral agreement disclosures set forth in this legislation are designed to insure that consumers who purchase funeral goods and services in advance make informed decisions when purchasing a prearranged funeral agreement.

I appreciate the opportunity to appear before you today and ask for your support of this legislation. I would be happy to answer any questions you may have. Thank you.