Approved: 3-4-93
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 23, 1993 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

State Senator Don Sallee
John Eplee, M.D. - Atchison
Paul Adams, M.D., The Corporation for Change
Rick Kellerman, M.D. , President, Kansas Academy of Family Physicians - Salina
Monica J. Goldsberry, Director of Immunization Section, Bureau of Disease Control, Kansas Department of Health and Environment
Bruce C. Snead, State Specialist, Engineering Extension, KSU, Manhattan
Stephen E. Albright, Radon Measurement and Diagnostics, Lawrence
Gary Hodgden, Midwest Radon, Olathe
Carol Macdonald, Kansas Dental Board
Kim Stabbe, Kansas Dental Hygienists
David Hanzlick, Kansas Dental Association

Others attending: See attached list

The Chair opened the hearing on **SB 92** - Immunization of children for infectious diseases.

State Senator Don Sallee, sponsor of **SB 92**, expressed his support of the bill that would require the Department of Health and Environment, beginning January 1, 1994, to provide vaccines at no cost to private physicians in Kansas for the immunization of children. Physicians would be allowed to charge a reasonable fee for the administration of the vaccine, but the fee could not be more than the administration fee charged at the local health department. The Department currently provides vaccines at no cost to local health departments, which charge an administration fee for the immunization.

John Eplee, M.D., is a family physician practicing in Atchison and recipient of a six-month Pilot Project which came about as a result of the 1992 meetings of the Immunization Task Force, the Kansas Medical Society and the Kansas Department of Health and Environment in order to evaluate the effectiveness of private providers receiving state and federal vaccines. Under **SB 92** the Secretary of Kansas Health and Environment would provide for distribution of children's vaccines to qualified physicians for administration to children who receive health care and are not properly immunized. The vaccines would be purchased by the Secretary pursuant to contracts between the manufacturer and a federal agency or negotiations in accordance with applicable state purchasing laws and distributed at no cost to the qualified physician. Physicians may charge a reasonable fee for administration of children's vaccines. Dr. Eplee submitted written testimony in support of **SB 92** stating many parents no longer bring their children in for well baby visits, because they know they will not be able to get immunizations at an affordable cost from their doctor, and this bill would allow for an affordable method of disease prevention. (Attachment 1) In answer to a member's question regarding if parents would be reimbursed by their insurance company for immunization of their child in a doctor's office, Dr. Eplee stated it would depend on the third party payer -- Blue Cross/Blue Shield does pay the physician approximately one-third of the cost through one program.

Paul Adams, M.D., representing The Corporation for Change, and Rick Kellerman, M.D., Kansas Academy of

Family Physicians, both appeared before the Committee and submitted written testimony in support of **SB 92**. (Attachments 2 and 3)

Monica J. Goldsberry, KDHE, appeared in opposition to **SB 92** stating it is not proven that providing private providers with state/federal vaccine increases immunization rates, removes immunization barriers or provides more services to the clients. The state of Kansas has an average amount of vaccine purchased off of each contract per year. When the state exceeds that amount, the drug companies have reason to question the orders, and if purchases are denied, then the state must purchase vaccines at the market price. A private provider pays wholesale prices which are considerably more expensive than purchasing vaccine from a federal contract. Ms. Goldsberry noted that the major expense of **SB 92** would be for vaccine purchased at the increased wholesale costs. (Attachment 4) Written testimony was also received from Richard A. Nelson, Merck & Co. (Attachment 4a)

Hearing on **SB 311** - Radon certification act.

Bruce Snead from K-State, Stephen E. Albright with Radon Measurement & Diagnostics, and Gary Hodgden of Midwest Radon appeared before the Committee and submitted written testimony in support of **SB 311.** (Attachments 5, 6 and 7) The bill would be known as the Radon Certification Act, and the Department of Health and Environment would be required to establish a certification process for radon-related professions and grant certain authority to implement the act. Among those powers would be the authority to charge fees to cover program costs. All fees would be deposited in the Radon Certification Fee Fund created by the act, and expenditures from the fund would be subject to appropriations and limited to the radon program operations. Certain radon professionals would be required to report certain data to the Department within 30 days of any test or mitigation work. Written testimony in support of the bill was also received from Theresa Nuckolls -- Attorney General's Office, Harold Spiker -- Kansas Department of Health and Environment, and Mary Jo Kleiger -- Kansas Homeowner. (Attachments 8, 9 and 10) No opponents testified on the bill.

Hearing on **SB 308** - Licensure of dental hygienists.

Carol Macdonald, Kansas Dental Board, appeared before the Committee and submitted written testimony in support of **SB 308**. One of the main issues of this bill is general supervision that would allow a hygienist to perform routine hygiene services without the presence of a dentist. The issue of administration of local anesthetic by a hygienist is found in amended KSA 65-1456 (d)(1), and the Kansas Dental Board is currently in the process of adopting rules and regulations which would allow this. The public hearing on this issue will be held March 10, 1993, in Emporia. (Attachment 11) Kim Stabbe, Kansas Dental Hygienists, also appeared in support of the bill, as well as written testimony from Sandra Strand, KINH. (Attachment 12)

David Hanzlick, Kansas Dental Association, appeared in opposition to **SB 308**, and submitted written testimony from two dentists, Scott C. Kennedy, D.D.S, and Cynthia Sherwood, D.D.S. (Attachments 13 and 14) Mr. Hanzlick stated the KDA governing body will be meeting this weekend to discuss the rules and regulations as proposed by the Kansas Dental Board.

The meeting was adjourned at 11:00 A.M.

The next meeting is scheduled for February 24, 1993.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 2-22-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Theresa Marcel Nuckolls	AG Topeka	Robert T. Stephan
Tom Hitchcock	Topeka	Bd. of Pharmacy
Kathy Peterson	Topeka	Connaught Labs
Frank Caso	K C	Merck + Co. Inc
Cindi Sherwood, D.D.S.	Independence	K.D.A.
Scott Kennedy D.D.S	Topeka	K.D.A.
Carl Schmitthenner	Topeka	Kansas Dental Assn.
HARRY SPRONG	K.C.	HUMANA
PAUL ADAMS	OSAGE CITY	CORP. FOR CHANGE
Doug Bowman	Topeka	Corporation for Change
Carol Macdonald	Topeka	Ks. Dental Board
Mary Jo Kleiger	Topeka	Consumer
[illegible] Lee MD	Atchison	Private Physician
Chip Wheelen	Topeka	KS Medical Soc.
Pamela Meeker	Leawood KS	S. & B. Corp.
Deborah Alfano	KDHE/Topeka	KDHE
Monica Goldsberry	KDHE/Topeka	KDHE
Danielle Dee	Topeka	Wichita Hosp Assoc
Ray Reecee	"	NARFE
David Thomasson	Topeka	SRS
Rick Kellerman MD	Salina	KAFP
Jean Taylor	TOPEKA	Advocacy Intern W.U.
Margaret Biethman	KC, KS	KS Dental Hygienists' Ass

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 2-23-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Kim Stubbs	O.P. KS	KS Dental Hygienists' Assn
Harold Riekm	Topeka	KAOM
Keith R Landis	Topeka	Christian Sciences Comm on Publication for KS
Jim Yonally	Overland Park	KDHA
David Hagzlick	Topeka	KS Dental Assn

February 23, 1993

TESTIMONY
to
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
on
SENATE BILL 92

Thank you Madam Chair and members of the committee. My name is John Eplee. I am a family physician practicing in Atchison for 12 years. I am board certified in family practice and also a fellow of the American Academy of Family Physicians. I am currently President-Elect of the Kansas Chapter of the A.A.F.P. and represent 640 family physicians in this state and 2,800 physicians who are members of the Kansas Medical Society.

I submit to you that immunization access, distribution and vaccination is at a crisis point in the state of Kansas. The most recent data that we can look to is from school year 1990-91. At that time, 48.7% of all children 2 years and younger in our state were not fully immunized. This is 10% less than dismal national data. In my own county only 37% of all children were properly immunized by age 2.

To understand this problem, one must briefly review the history of immunizations in our state. When I began practice in Atchison in 1981, I was able to obtain vaccines from the County Health Department and at no cost administer them to my private patients. We charged a $2 administration fee only. This was the same fee as the County Health Department. The County Health Department was happy to distribute vaccines to me and we were happy to give it to our patients. Although I do not have the data to back it up, I would venture that immunization levels were much higher at that time.

Then enters the liability monster. In the fall of 1983, there were literally hundreds of cases of litigation filed against the pharmaceutical companies that make the vaccines because of the "untoward reactions" and "allergic reactions." Therefore, the cost of vaccine climbed dramatically. About two years later, K.D.H.E. sent out a memo that prohibited County Health Departments, etc. from distributing vaccines to private providers (i.e. physicians). Because of the liability issue, over the years the cost of vaccines has climbed dramatically. Private physicians are now forced to purchase all immunizations in Kansas at the retail cost. The retail cost for the MMR currently is nearly 2 1/2 times the federal purchase price as it's obtained by Kansas Department of Health and Environment. The retail cost currently is $24 whereas K.D.H.E. pays $10.67 for the same vaccine purchased through the Centers for Disease Control contract. In turn, K.D.H.E. gives the vaccine to the county health department, which then charges an administration fee covering the cost of the syringe, nurse, time, etc.

Senate PH&W
Attachment #1
2-23-93

When this program was originally established by the drug companies, the federal contract vaccine was to be distributed only to indigent and Medicaid patients. Of course, as we all know, one of the basic tenants of our state Department of Health and Environment and the County Health Department is to offer their services to all Kansans who choose to come in. This is as it should be. It is my understanding that the pharmaceutical companies are aware of this situation even though it is a direct contradiction in the terms of the C.D.C. contract. It is an apparent breach of the contract between the pharmaceutical companies and C.D.C.

The ultimate coup de grace is that the drug companies have it clearly written in their contract with C.D.C. that they can opt out of their C.D.C. price with a particular state if they discern that they are administered to patients other than the indigent poor. To the best of our knowledge they've never exercised that option in a single state. However, I would anticipate hearing that line of logic being put forth by opponent members of the pharmaceutical lobby in our state.

In simple terms, the real issue is money and profit for pharmaceutical industries. All that's gone on for the last 10 years in our state is what I call cost shifting. Drug companies have shifted the cost of vaccine to physicians and to their patients in order to subsidize their lack of profit under the C.D.C. contract. We will hear that if this legislation is enacted, that it will require that they opt out and raise the price to K.D.H.E. And of course, there will be no money left then for research and development.

The ultimate barrier comes when, in most rural counties, the County Health Agency is only open one or two days a week or a month for immunization clinics. This poses an incredible barrier to access immunizations for Kansas parents and young children. The barriers are there and they are insurmountable for many working Kansans when County Health Departments are only open a half day each week. In Atchison County, residents of Northeast Kansas simply cannot always take off work to take their child to County Health Department. There are multiple opportunities in the physicians offices, either at the time of illness or for regular well baby visits and this is where the real health care disaster comes. Over the last five years I've seen a marked decrease in the number of parents bringing their children in for well baby visits. I want to assure you that in Northeast Kansas we are not wanting for more patient visits at this time. However, well baby visits are an essential part of infant and childhood health care. I feel at a minimum parents should be offered this service.

Many parents no longer bring their children in for well baby visits because they know they will no longer be able to get immunizations at an affordable cost from their doctor. Therefore, it is easier to simply miss the visit. I know of at least three examples in my practice where those missed well baby visits have resulted in catastrophic health care consequences for individual patients. In one case, a dysplastic hip was missed because the parents did not

bring the child in until one year of age for an office visit and it was only at that time that we discovered the child had a congenital hip dislocation. This will result in permanent arthritis, disfigurement and ultimately surgery for this child. Example two is that of a child with a congenital heart lesion that was not picked up until six months of age on the first visit to the office when the child was in congestive heart failure. This is a simple lesion that could have been picked up on a routine well baby visit had the parents simply brought the child in for that well baby visit and to seek immunizations. The third example is of a child with pyloric stenosis who was finally brought in, at three months of age, malnourished, very dehydrated, near death. He had to ultimately be transferred to a tertiary care hospital for definitive treatment. Fortunately the child lived. None of these children had any immunizations. In addition, well baby physicals are not offered at County Health Departments. These missed opportunities to affect quality health care are extremely disturbing.

Nationally, millions if not billions of dollars are saved because of immunizations. Infants and children quality of life are improved and their frequency of infection, illness, etc. are markedly diminished. Although there is no way I can statistically prove this I am certain that by immunizing all infants and children in our state through physicians, county health departments, etc. the cost savings in diminished illness, utilization of health care, etc., would more than pay for the cost of the vaccine. Being immunized should be a fundamental right, not a privilege. This is an issue that is right for the State at this time. It will markedly improve access to disease prevention for thousands of Kansas infants and children.

Arrangements like this have been set up in many other states. Some of them do not have state health agencies, however others do. In those states where physicians have been allowed to give immunizations, the rates of children being immunized at age 2 is markedly improved. In addition, reporting and record keeping is markedly improved in those states such that we can better document rates of improvement in vaccine administration.

No longer will immunizations be a privilege for those parents and children that can get to the immunization clinic on the day that the clinic is held. It will be a freely accessible method of disease prevention available to <u>all</u> Kansans. The United States is one of the last major developed countries not to have a system of this nature. At least, let's adopt this system in our own state. The attachment refers to a national program that is being considered at this time, very similar to the legislation we have before you today. Indeed, this is an important issue both at a state and national level. However, I'm no longer willing to stand by and wait for the federal government to take action. Kansas children cannot afford to wait.

Thank you for your consideration. We urge you to recommend SB 92 for passage.

The Topeka Capital-Journal, February 13, 1993

Clinton expands vaccinations

By NANCY BENAC
The Associated Press

ARLINGTON, Va. — Accusing drug companies of charging "unconscionable" prices, President Clinton announced a $300 million program Friday to make vaccines available to a million more American children.

"Our nation is the only industrialized nation in the entire world that does not guarantee childhood vaccinations for all children," Clinton said after visiting a community clinic that offers free shots. "It ought to be like clean water and clear air. It ought to be a part of the fabric of our life."

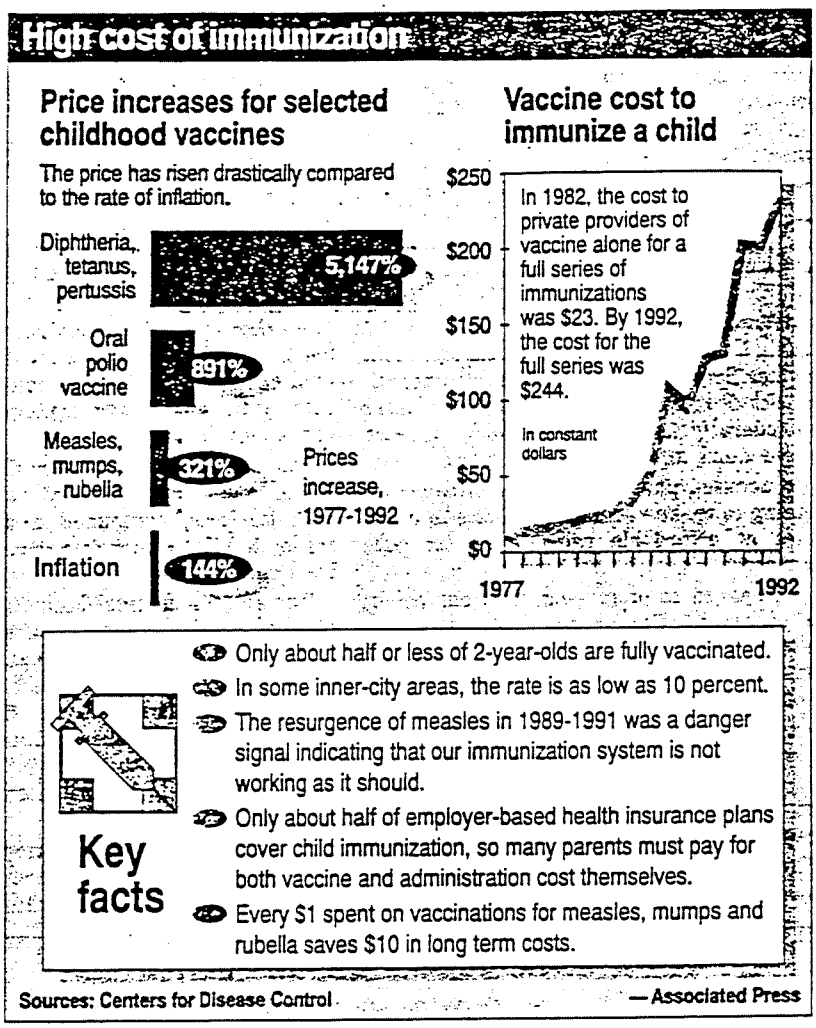
He had strong words for the nation's drug makers, saying it was a "cruel irony" that American pharmaceutical companies make most of the world's vaccines but charge more for them here than they do in other countries.

Only about half of America's 2-year-olds are fully vaccinated, and the rate is as low as 10 percent in some inner-city areas, according to federal health experts. In the Western Hemisphere, only Bolivia and Haiti have lower immunization rates than the United States.

Clinton, accompanied by his wife, Hillary, promised his economic stimulus package would include an extra $300 million to promote immunization efforts this year at clinics in underserved urban and rural areas. He also promised increased federal financing in future years.

In addition, he directed Health and Human

Continued on page 2-A, col. 1



Continued from page 1-A

Services Secretary Donna Shalala to negotiate with drug companies to make sure states and federally assisted health programs can buy vaccines at "reasonable" prices.

He accused pharmaceutical companies of refusing to make vaccines available to many states at affordable rates, even for bulk purchases.

"Compared to other countries, our prices are shocking," Clinton said. "We must tell the drug companies to change those priorities. We cannot have profits at the expense of our children."

Overall, he said, vaccine prices have risen at six times the rate of inflation over the past 10 years, at a time when drug companies are spending more on advertising and lobbying than they do to develop new drugs.

Clinton said he hoped drug companies would be involved in developing legislation to further expand immunization programs, but added, "Whether they are or not is up to them. But this is unconscionable. We are running the risk of new epidemics spreading out in this country."

Shalala offered more conciliatory words, saying she looked forward to negotiations with the drug companies and had "every reason to believe that they care about America's children, too."

The Pharmaceutical Manufacturers Association, which represents drug companies, referred all calls to individual drug companies.

Lederle-Praxis of Wayne, N.J., issued a statement saying it shared Clinton's goals of expanding access to vaccines but made no direct response to his criticisms of the drug industry.

Clinton said that in addition to lowering the costs of vaccines, the country needs to improve access to immunizations.

1-4

BEE WISE IMMUNIZE

all your life

CONSUMER ADVISORY

Immunizations can prevent: serious diseases/ their complications/death.

As a consumer you have the ability to protect yourself and your loved one from very bad diseases such as:

- Measles, Mumps, & Rubella
- Diptheria, Tetanus, & Pertussis
- Hepatitis B
- Influenzae
- Polio

By immunizing, you protect yourself from complications such as:

- Blindness
- Brain damage
- Convulsions
- Deafness
- Pneumonia
- Death

Call your physician or local health department.

Do it for yourself and for your children. Remember immunizations are an important part of your total health care

All proceeds from the sale of these cards will benefit Kansas Immunization Task Force. To order call (913) 233-8638 Kansas State Nurses' Association

Immunize on Time 2, 4, 6, 15 months and when entering kindergarten

Recommended Immunization Schedule

Age	Vaccinations
Birth	HBV1
2 mo.	HBV1 or 2. DTP. OPV. Hib1 or 2
4 mo.	HBV2. DTP. OPV. Hib1,2
6 mo.	HBV1 or 2. DTP. Hib1
1 yr.	Hib2
15 mo.	DTP. OPV. MMR. Hib1
4-6 yrs.	DTP. OPV. MMR
14-16 yrs.	Td plus every 10 years throughout life.
65 yrs. & older	Influenza. pnemococcal

HBV Hepatitis B Vaccine - May be given in either of 2 schedules:
HBV1 Birth. 1-2mnths.. 6-18 mnths OR
HBV2 1-2 mnths.. 4 mnths.. 6-18 mnths.

DTP Diphtheria. Tetanus. and Pertussis

OPV Oral Polio Vaccine

Hib Haemophilus b Conjugate Vaccine
Hib1 is given at 2. 4. 6. & 15 mnths OR
Hib2-OMP is given at 2. 4. & 12 mnths.

MMR Measles. Mumps. and Rubella

Td Tetanus and Diptheria

Influenza yearly

ACIP recommended 1992

Table 1:

Prices Per Dose of Childhood Vaccines in the Public and Private Sectors as of June 30, 1991

Public Sector		Private Sector	
Vaccine	Price	Vaccine	Price
MMR	$15.33	MMR	$25.29
OPV	$ 2.00	OPV	$ 9.45
DTP	$ 6.24	DTP	$ 9.97
HiB (2,4,6,15 months) Hibtiter™ (Praxis Biologics, Inc. Lederle)	$ 5.16	HiB (2,4,6,15 months) Hibtiter™ (Praxis Biologics, Inc. Lederle)	$14.55
Td	$ .15	Td	$ .83

Source: Centers for Disease Control, Center for Prevention Services, Division of Immunization.

5. *Vaccines and Professional Supplies.* Vaccine supplies totaling $1,268,391 for FY 1994 and $1,212,314 for the current year are included in the agency's Aid to Local Units program. The FY 1994 request includes $527,120 for diphtheria, tetanus, and pertussis (DTP) vaccines (88,000 doses at $5.99 per dose), $5,079 for 700 doses of Inactivated Polio Vaccine (IPV), and $736,192 to provide measles, mumps and rubella (MMR) vaccine (48,023 doses at $15.33 per dose). The MMR request will provide for all Kansas newborns to be vaccinated and for state funding of 50 percent of the second dose of vaccine for adolescents, with the remaining 50 percent provided through federal direct assistance. The FY 1994 request includes $1,189,135 from the State General Fund and $79,256 from federal funds (the same amount of federal funds as the current year). Actual FY 1992 vaccine expenditures were $1,111,570 (all from the State General Fund).

5. The Governor concurs with the agency's request for each fiscal year. In addition, the Governor adds $1,690,617 for FY 1994 and $1,162,441 for the current year from the Sponsored Project Overhead Fund for vaccines and professional supplies. The recommendation totals $2,959,008 for FY 1994 and $2,374,755 for the current year.

STATE PROGRAMS PROVIDING FREE VACCINES TO PEDIATRICIANS

The following are descriptions of existing state programs that distribute vaccines, free of charge, to physicians. If AAP chapters were involved in the creation of the program, their experiences are also described. These insights may assist with your efforts to initiate a similar program in your state. To learn more about these state programs, please contact the immunization program manager for the individual state on the attached list of program managers.

NEW ENGLAND STATES

Because states in New England have either no or very limited local health department services, the state has traditionally relied on a public/private partnership to provide vaccines to children in the state. Although there are variations in the state program, in general the state purchases sufficient vaccine for all children in the distributes vaccines to physicians free of charge. In return, the providers must account for the vaccine used.

Vermont

Vermont's Department of Health provides vaccines free of charge, with the exception of the second measles and the three early Hib vaccines, to pediatricians' offices. The program is decentralized with twelve district offices distributing vaccines to eligible physicians, who cannot charge patients for the vaccine materials but can charge a small administration fee. When physicians pick up a new supply of vaccine from the district offices, they are required to report information according to CDC regulations on the vaccines previously administered. Ninety percent of children are immunized through this program and the other 10% receive their immunizations at well child clinics at the 12 district offices. The program is funded by a CDC grant of about $300,000 and the state pays an additional yearly sum of about $350,000.

Rhode Island

Rhode Island's vaccine program is funded with a grant from the CDC which pays for 72% of the program and the remaining 28% is paid with state funds. Although no legislation mandates the provision of vaccines, it has been common practice for the state health department to distribute vaccines to private pediatricians. The state contracts with 10 hospital pharmacies, which distribute the vaccine to physicians. Participating physicians may charge an administration fee. They are supposed to complete a card on each state funded vaccine administered and return it to the state. The record keeping system is not accurate as only two-thirds of the vaccines are accounted for with this system. All vaccines except the second MMR and the 2,4,and 6 month Hib vaccine are distributed.

The second dose of measles can be obtained by 6th grade at neighborhood clinics and the early Hib vaccines are distributed to physicians for use by their Medicaid and uninsured patients only. The Rhode Island Chapter of the AAP is lobbying for additional state funds to purchase adequate doses of the newly approved vaccines for all children.

New Hampshire

New Hampshire's immunization program costs about $1 million a year. Half of the funds come from a CDC grant and the other half are supplied by the state. Vaccines are shipped directly to private physicians' offices. Currently the program does not fund the second MMR vaccine and the 2, 4, and 6 month Hib vaccines. However legislation has been introduced to appropriate additional funding which will enable the state to purchase the vaccines. Ninety percent of the immunizations given in the state are administered by private physicians, and the remaining 10% are given by the three local health departments. Physicians are required to submit a usage report accounting for the vaccine given upon reordering more.

Massachusetts

The state of Massachusetts has manufactured and distributed the DTP vaccine since 1920. The legislature originally created a vaccine trust fund to finance the program. As other vaccines became available, they were also provided to physicians free of charge. In addition to all the AAP recommended vaccines, hepatitis vaccine and influenza vaccines are also provided for high risk groups. Vaccines are stored in five depots in the state from which vaccines are distributed to county boards of health. Upon picking up additional doses of vaccine, physicians must submit usage reports to account for the earlier doses. While physicians cannot charge for the vaccine, they can charge a nominal administration fee. In 1991, of the $10 million cost of the program the state paid all but $2 million.

Maine

Maine's vaccine program provides only DTP and MMR vaccines to the private physicians' offices; all other vaccines can be obtained free from public health clinics. Private physicians using public vaccine may charge no more than a $2.00 administration fee. In 1991, the state funded 45% of the $833,000 program and the remainder of the funding came from the CDC. Vaccines are shipped directly to physicians from the state lab in Augusta.

Connecticut

Connecticut provides all vaccines recommended by the Academy except the Hib vaccine to private physicians free of charge. In 1991 the immunization program cost about $4 million with the state paying three quarters of the total and the CDC grant paying the other quarter. Physicians can order the vaccine by mail and have it shipped directly to them. Physicians are required to submit usage reports to account for delivered vaccine. All but 4-5% of the state's vaccine supply is accounted for by this system.

OTHER STATES

Alaska

Alaska provides vaccines for all children in the state. Sixty percent of vaccines are administered at the state's twenty-four public health centers by public health nurses; the remaining 40% are administered in private physicians' offices. Physicians can have the vaccine mailed to them or they can pick them up in Anchorage, Fairbanks or at the state lab in Juneau. Physicians may charge an administration fee and the state has recommended that it not exceed $10. Sixty percent of Alaska's immunization program budget is funded with state dollars.

Idaho

In 1990 the Idaho legislature appropriated $1 million for a one year trial state immunization program. The program was a direct response to the public health community's concern with Idaho's low preschool immunization rates; the goal was to increase this group's immunization rates from 80% to 95%. The program provides free vaccine to any physician willing to sign a contractual agreement with the state health department. Under the agreement, physicians must: 1) account for all vaccine given by dose and age group, 2) not charge more than a $10 administration fee, 3) monitor the temperature of storage units, 4) return the vaccine shipping boxes to the state, 5) post a sign in the office stating the no patient will be denied immunization due to inability to pay, 6) agree to site visits, 7) use an immunization record card and 8) reimburse the state for any vaccine that was damaged by the physician's negligence. All AAP recommended vaccines are shipped directly to physicians' offices. In addition, children can receive vaccines free of charge at public health clinics. Since dropping a previous administration fee, public clinics have seen a 30% to 50% increase in the number of children receiving their immunizations at clinics. Thus far 133 physicians are participating in the program; the state is hoping to recruit more. For fiscal year 1991 the program is funded with $1.3 million in state dollars and $400,000 in federal dollars. The pilot is expected to continue for at least another year.

South Dakota

Every January physicians must sign a contract with the state in order to receive vaccines free of charge. In return, physicians are required to file a monthly report accounting for the vaccine administered. The state purchases vaccines for all children with funds from a CDC grant and contributes only a small portion of state funds to finance the program. Sixty percent of the state purchased vaccines are administered by private practice physicians.

Washington

In 1990, the Washington Chapter of the Academy worked with the the state health department to put $1.1 million additional dollars in the governor's budget to purchase enough vaccine for all children in the state. Backed by the state medical association, the chapter convinced the administration that the current system was inequitable because the state purchased only 70% of the needed vaccine. Therefore children could obtain their vaccines at their private physician's offices for a small administration fee as long as vaccine was in supply. Once the supply for the state was depleted, patients had to pay the full private price for the vaccine or they had to go to public clinics for their immunizations. The additional funding now provide vaccine for all children.

Wyoming

Since the beginning of the Wyoming immunization program 15 years ago, the state has supplied private physicians with all recommended childhood vaccines. Eighty percent of physicians in the state receive vaccines. The state supplies 90% of all vaccine administered in the state; of that amount 50% is given by private physicians and 50% is administered at public health clinics. Physicians are barred from charging for the vaccine but may charge an administration fee. In 1991, the state paid 13% of the cost of the program and the CDC grant funded the other 87%.

North Dakota

Up until 1989, the state of North Dakota provided vaccines to pediatricians' offices, public health clinics and the Indian Health Service for all of the state's children. A computerized system tracked each child's immunization history and issued delinquent notices to pediatricians if immunizations were not kept up-to-date. In 1988 the program cost $700,000 and 70% of the vaccines administered were given in private physicians' offices. However, in 1989 due to a budget shortfall, the Governor was forced to cut the immunization program budget of the state health department. Currently, the state health department provides free vaccine at public health clinics to any child in the state, regardless of income.

Pediatricians in North Dakota report that many parents are not taking their children to the public clinics for immunizations because they prefer to have their children vaccinated at a private physician's office. After state funding for the immunization program had been cut, the health department pointed out two problems with the program: 1) some physicians had been charging excessive administration fees and 2) vaccines had been administered to Minnesota residents from border cities. The North Dakota Chapter of the Academy is currently promoting legislation to reinstate this program. The Chapter feels that this program is vitally important to the health of the children in North Dakota and therefore supports a bill that allows the health department to limit the administration fee charged by private practitioners who receive free vaccine from the state. The state's 1989 preschool immunization rate of 96.6% attests to the effectiveness of the program.

4/91

THE CORPORATION FOR CHANGE

A Partnership for Investing in The Future of Kansas Children and Families

Testimony before Senate Public Health & Welfare Committee
Senator Sandy Praeger, Chair
Senate Bill Number 92
February 23, 1993

by Dr. Paul Adams

The Corporation for Change is a public private partnership for investing in the future of Kansas children and families. By statute, we are charged with implementing a comprehensive, coordinated strategy for investment in Kansas children and families. The overriding goal of the Corporation is to coordinate and implement reform of children's services in Kansas.

Thank you for the opportunity to visit with you today and to discuss Senate Bill 92. The Corporation for Change supports strategies that will increase the immunization rates of young children. Our most recent data indicates that only one-half of all two year-olds are properly immunized. *The Blueprint for Investing in the Future of Kansas Children and Families* calls for increased efforts to improve upon that immunization rate. This bill would allow the Kansas Department of Health and Environment to give appropriate children's vaccines to qualified physicians. These physicians could then charge a fee for administration of these vaccines not to exceed that charged by the local health department.

Currently, most vaccinations are given by the local health department. Our concern is that many parents fail to make that additional trip over to the local health department. It would be much more convenient if physicians would give these vaccinations at the time of any visit to the doctor. We hope that this bill, making these materials available to the physician at no cost, will encourage more doctors to give these vital vaccinations.

Thank you for your time. I would be happy to answer any questions.

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Senate P&HW
Attachment #2
2-23-93

Senate Public Health and Welfare Committee
February 23, 1993
Topeka, Kansas
Senate Bill 92
"Childhood Immunizations"
Testimony of Rick Kellerman, M.D.
Kansas Academy of Family Physicians

Thank you, members of the Senate Public Health and Welfare Committee, for hearing testimony on SB92, concerning the immunization of children in Kansas. The immunization statistics in Kansas are dismal. The immunization delivery system in Kansas is chock-full of barriers to timely easy-to-obtain vaccination of our children.

My name is Rick Kellerman, M.D. I practice in Salina. This year I serve as President of the Kansas Academy of Family Physicians (KAFP). In June, 1991, our Academy's general membership unanimously approved a resolution outlining the concept of SB92. There is broad-based support from family physicians to remove barriers to immunization of children and support for SB92.

Allow me to take off my hat as KAFP President and explain what I've witnessed in my own practice. When I started practice in 1982, I compulsively and systematically vaccinated and kept vaccine records on the children in my practice. Vaccination was an integral part of my "well-child" and preventive care of children. Vaccines could be purchased and administered relatively inexpensively. I took great pride in keeping the children in my practice up-to-date on their immunizations.

I suspect that most parents equated "baby visits" with "shots" and were unaware that, as a matter of my routine, the growth, development and physical health of their children was also being systematically evaluated.

In the mid-1980's, as vaccine costs rose and as liability pressures mounted, I could no longer afford to buy vaccine and administer it in my office on a routine basis. I would fully explain the benefits, risks and monetary costs of vaccination and allow the parents to choose how to proceed. I told them they could obtain the child's vaccinations free-of-charge at the public health department. Most parents elected to forego their child's vaccination in my office when I told them the cost. I don't blame them.

I then noticed the following. First, parents weren't scheduling their children's "well-baby" check-ups. Second, when I saw the children for acute medical problems, they were behind on their

Senate PH&W
Attachment #3
2-23-93

immunizations. The health department only administers vaccinations during certain times on certain days. Parents had to take more time off work to drive to the health department for their children's vaccinations. Many just weren't making it there.

Because I can receive "replacement" vaccine for immunizations I administer to children who are in the Medicaid program, I continue to administer vaccinations to those children. Therein lies one of the perverse facts about our immunization delivery system. Children with Medicaid are immunized in my office. Children without Medicaid are referred to the public health department.

Because of this fact, it is my opinion that Kansas now has an implicit public policy that all children be vaccinated against childhood illnesses. Any child, no matter what the income level of their parents, can receive their vaccinations at their local health department for a minimal administrative fee. I think that is good, cost-effective public policy and should be made explicit. Part of the overall strategy to immunize children should include administration of state-purchased immunizations in physician offices.

To conclude, I have one final comment. We are seeing a re-emergence of diseases that could easily be prevented by full and complete immunization of children. Three years ago, we had an outbreak of measles in Salina with 64 confirmed cases and 36 suspected cases. There was unnecessary cost and confusion as our medical community and public health department worked together to control the disease and parental anxiety.

Last month I admitted my first case of culture-proven pertussis (whooping cough). Subsequently, there have been two other cases in Salina; one required transfer to Wichita due to the severity of his illness. He was discharged last Sunday after spending 21 days in the hospital. He is now four months old.

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

[redacted]

Robert C. Harder, Secretary Reply to:

Testimony presented to

by

The Kansas Department of Health and Environment

Senate Bill # 92

Testimony presented by : Monica J. Goldsberry
Director of Immunization Section
Bureau of Disease Control

Senate PH&W
Attachment # 4
2-23-93

Upon review of Senate Bill # 92, the Immunization Section, Bureau of Disease Control, Kansas Department of Health and Environment has noted several issues which concern the inactment of this Bill.

Senate Bill # 92 requests that vaccine be provided to all physicians for administration to the people of Kansas. The Issue of private physicians recieving State/Federal provided vaccine has arisen before. During the Immunization Task Force meetings of 1992, the Kansas Medical Society brought up the issue of private physicians receiving State/Federal provided vaccines as a means to eliminate immunization barriers for the children of Kansas. In joint cooperation, the Immunization Task Force, Kansas Medical Society, and the Immunization Section, Bureau of Disease Control of Kansas Department of Health and Environment agreed to a six month Pilot Project in order to evaluate the effectiveness of private providers receiving State/Federal vaccines. The Centers for Disease Control and Prevention (CDC) agreed to view this as a research project. CDC does not support providing private providers State/Federal purchased vaccines.

The Immunization Section agreed to allow the Kansas Medical Society to choose the Pilot Project participant. Dr. John Eplee of Atchison County was chosen. From May through November of 1992, Dr. John Eplee and his pediatric practice received State/Federal provided vaccines. Ruth Humbert, the Immunization Field Representative reviewed both the Local Health Department and Dr. Eplees' records. Upon review, it was noted that only 8 clients were immunized at Dr. Eplees' pediatric office that were not already Dr. Eplees' or his pediatric offices' clients. The Pilot Project did not remove a barrier by providing additional sites, the parents just changed immunization locations from the Local Health Department to Dr. Eplees' pediatric practice.

It is not proven that providing private providers with State/Federal vaccine increases immunization rates, removes immunization barriers or provides more services to the clients.

Other states have provided State/Federal vaccine to private providers in the past. The State vaccines were then used to that providers discretion usually regardless of the Advisory Committee on Immunization Practices (ACIP) immunization schedules. Additional scenarios included mishandled vaccines, clients being charged as high as $ 40 for vaccine administration, and physicians were unwilling to allow the state to audit records. Because of office schedules, vaccines sometimes arrived when offices were closed for the day or afternoon. Private physicians complained that the State was trying to tell them how to practice medicine. In addition, physicians refered clients, who could not pay an administration fee, to the Health Departments.

How can the state monitor vaccine handling, vaccine practices, and administration fees? The State of Kansas has only 2 Immunization Field Representatives. Site visits cannot be performed on each vaccine recipient.

The State of Kansas has in place an SRS Vaccine Reimbursement Program. Physicians purchase the original lot of vaccine, then submit a claim on each vaccine administered. SRS reimburses this vaccine upon each vial used. If indeed, all providers would give vaccine to all clients, regardless of ability to pay, the SRS Vaccine Reimbursement program would no longer be needed. Also, the federal funding which provides the SRS Reimbursement Vaccine would also be lost.

The State of Kansas purchases vaccine off the "Option to Buy" clause of the CDC Federal vaccine contracts at a drastically reduced rate. Each vaccine distributor has the right to refuse any order purchased from this clause. The State of Kansas has an average amount of vaccine purchased off of each contract per year. When the State exceeds this amount, the drug companies have reason to question our orders. If purchases are denied, then the State must purchase vaccines at the market price. A private provider pays wholesale prices which are considerably more expensive than purchasing vaccine from a federal contract.

The State estimates that Public Health provides vaccine to approximately 65 to 70% of the children of Kansas. The major expense of SB92 would be for vaccine purchased at the increased wholesale costs. Dependent upon the vaccine, purchases for the State may increase an average of 30%. In selective vaccines, such as IPV, the State purchases only 500 doses per year. These vaccine purchases may increase as much as 400%. Please note Fiscal Impact Statements below.

It is estimated that the refrigeration and freezer space, dry storage space and personnel would need to be increased approximately 20%-30%. Shipping and handling costs is expected to increase 75% since private providers would require smaller and more frequent mailings. Additional In-house Staff will be required to handle the increased shipping and storage requirements.

Recommendations:

The State of Kansas and the Centers for Disease Control and Prevention purchase enough vaccine for 70% to 87% of the children of Kansas to be age-appropriately immunized. **(Please note that these percentages do not include private sector sales.)** Purchasing additional vaccine even at a discounted price would not solve the problem of low age-appropriate immunization rates. Quantity of vaccine is not the issue. **An emphasis on reaching parents and educating them about the importance of age-appropriate immunization is the issue.**

The Immunization Section, Bureau of Disease Control, Kansas Department of Health and Environment recommends that an alternate means of seeking higher immunization rates begin with mandated insurance coverage of vaccine and vaccine administration. SRS already has an operational vaccine reimbursement which provides

state purchased vaccine for the medically and financially indigent clients to receive immunizations in private provider offices.

1993 KANSAS LEGISLATURE

Senate Public Health and Welfare Committee
Senate Bill No. 92

Written Testimony of MERCK Vaccine Division
Tuesday, February 23, 1993

We are pleased that through SB 92 Kansas is focusing the need to improve your childhood immunizations. Merck applauds you for this.

Two years ago, The National Vaccine Advisory Council made a careful analysis of our system's shortcomings and, in its report entitled "The Measles Epidemic: The Problems, Barriers and Recommendations," cite 13 barriers to childhood immunization. Vaccine cost was not one of them.

Rather, the barriers cited in the Committee's report were all a function of the system's failure to reach children in inner-city and rural areas--children who were already eligible to receive free immunization through public sources. This Committee correctly focused on the general unavailability of services--when and where parents need them--as a chronic, national impediment to full vaccination.

Yet, today, SB 92 is proposing that the solution to the immunization problem is for state government to buy the entire supply of childhood vaccine and distribute these vaccines free to public clinics and private physicians. While this proposal has captured the hearts of some, it cannot succeed in improving immunization rates, because it ignores the principal obstacle to immunization: inadequate access to services.

A State universal purchase program would do little if anything to address severe infrastructure problems, such as underfunded and understaffed public clinics and the exodus of office-based physicians from Medicaid. In fact, an additional infrastructure obstacle would be added: a very expensive and duplicative state distribution system.

To date, experiences with state universal purchase plans are far from encouraging. Immunization rates in the six New England states, which have universal purchase plans in place, are not significantly higher than states that do not have such plans.

With an average of only 63 percent of their children vaccinated, the 12 states with universal purchase plans are not doing much better than the national average of 58 percent. And Vermont--often cited as a model program, with the highest immunization rate of the 12--is currently experiencing a measles epidemic.

Senate PHHW
Attachment 4a
2-23-93

Thus far, nine states have considered adopting universal purchase systems. But after examining the realities and the record, all nine states have now rejected universal purchase programs.

The universal purchase debate has served to distract us from the larger issues that really are having an impact on health care--issues such as the failures in the delivery system infrastructure, the lack of sufficient public education about health care and the need for first dollar insurance coverage for immunizations.

These are the issues we should be focusing on. These are the areas where we can make meaningful changes. We at Merck believe that to improve the health of our people--both young and old--Government and the private sector must work together and draw upon the strengths of one another.

We support seven elements that we would like to see included on the state's unfinished immunization agenda. We believe that this is a constructive proposal that reflects both our national goals and the fiscal reality. Our seven elements are:

1. **Reach the children early.**

   Our record of immunizing school-age children is excellent--97 to 98 percent of America's children are fully immunized by the time they enter school. The concern--entirely justifiable--is for those children, particularly the poor and disadvantaged, who are at risk before they even reach school age. If we can immunize children before they reach two years of age, the health benefits down the road will be incalculable.

2. **Maximize coverage of non-Medicaid children.**

   Our concern must extend beyond those who qualify for Medicaid-supported free immunizations. We need insurance reform to provide for first dollar coverage of all childhood immunization. With such Reform, we could reach 60-65 percent of America's children.

3. **Heighten public awareness of the need for immunizations.**

   Ignorance is a tremendous barrier to immunization. Aggressive community education initiatives promoting full and early immunization will help to eliminate this obstacle.

   Many health-care professionals believe that the lack of a consistent relationship with a pediatrician is one reason some of the poor are not aware of immunization schedules. A comprehensive communi-

ty education program would address this problem. In an ideal world, everyone would receive care from physicians whom they know and whom they feel comfortable with. Sadly, that world is still far away. But we can begin now to bring it closer. And, as a company, we are investing $5 million over three years in the Merck Immunization Initiative to support creative local projects that will make immunization services more accessible.

4. **Eliminate additional barriers for the nation's poor.**

In addition to ignorance, we must tear down other barriers to immunization. We need to support vaccine delivery in public clinics and private physicians' offices and encourage doctors to vaccinate, rather than refer, patients. Research shows that vaccinations referred tend to become vaccinations deferred.

We have responded with the Merck Medicaid Program for Vaccines, which will enable states to buy pediatric vaccines at a reduced price for Medicaid-eligible patients. This is consistent with our corporate commitment to make all of our pharmaceutical products available to state Medicaid programs at the lowest price we charge any group purchaser, public or private.

Under this program, Merck will send each physician a "seed" shipment of vaccines at no cost. The states will pay Merck directly for vaccines actually used by private physicians, and we will continue to restock the vaccine supplies of program participants. This way, private physicians do not have to carry the cost of vaccines and will always have vaccines available.

Our program is about to be tested in Virginia and Arizona. We are offering it to Kansas. We are very optimistic about this program's potential for removing additional roadblocks to immunization. The Merck Medicaid Program for Vaccines shows what can be done through a creative partnership of private and public sector ideas to eliminate barriers.

5. **Mandate immunization coverage under Medicaid.**

To further improve immunization rates, we must mandate immunization coverage of parents who are living at a level of up to 185 percent of poverty. Merck is willing to offer vaccine at CDC prices for those living at a level of up to 200 percent, so that we can insure this coverage.

6. **Pursue scientific innovations to reduce barriers to immunization.**

Technological advances also break down the barriers to immunization. For example, Merck has developed a combined measles, mumps and rubella vaccine--M-M-R®. Combined vaccines means fewer shots, fewer visits to the doctor and less trauma for children and parents. And we shouldn't overlook this last point, because some believe that the trauma of an injection is a significant barrier to completing a vaccine regimen.

In addition to our combined measles, mumps and rubella vaccine, Merck has nearly completed nearly three decades of developmental work on a vaccine to prevent chicken pox. Once it is approved, we plan to combine this vaccine with our M-M-R® shot.

We are also working on a hexavalent product that would combine the DTP vaccine (diphtheria, tetanus and pertussis), a high-potency inactive polio virus vaccine, Hib meningitis vaccine and hepatitis B vaccine to greatly reduce the number of shots necessary for childhood immunization.

Researchers are also working on encapsulating vaccines in liposomes, or microscopic beads, that the body breaks down over time. By altering the chemical composition of these beads, we hope to time the release of antigens in the body, making it possible to provide--again, with one shot--protection against diseases that now require multiple injections at varying intervals.

7. **Develop a national tracking system.**

Last--but certainly not least--we need a government/industry initiative to develop a tracking system as a means of improving our national immunization rates. Under Merck's immunization initiative, for example, we recently provided a grant to the state of Oregon to develop a tracking system.

We hope that Oregon can develop a system that will serve as a model for the nation; because if we are serious about universal immunizations, we need to have a workable national tracking system.

We believe these seven elements must be present in any program for universal immunization. And, as you can see, these elements provide ample opportunity for industry and government to continue to work effectively together--just as we have done in the past.

4a-4

We at Merck stand ready--and willing--to work with the state of Kansas and other concerned groups to achieve our mutual goal of improving the lives of all Americans--young and old alike.

Respectfully submitted,

Richard A. Nelson
Regional Operations Executive
Merck & Co., Inc.
Vaccine Division
322 Blackberry Lane
Yorkville, Illinois 60560
(708) 553-5386

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TESTIMONY FOR SB 311 - Radon Certification Act
Given before Senate Public Health and Welfare Committee on February 23, 1993.

Given by Bruce C. Snead State Specialist - Instructor
Engineering Extension
133 Ward Hall - KSU
Manhattan, KS 66506 PH. 913-532-6026

My name is Bruce Snead and I work for Engineering Extension at Kansas State University. Thank you for holding this hearing and considering this bill.

I believe this is the key question facing this committee: Why should someone who is selling a service to perform radon tests or fixing buildings with radon problems be required to meet minimum qualifications or follow specific standards?

They should because in any testing situation, except where a homeowner tests to determine their personal exposure, there are competing interests in the result. In a real estate transaction, where most testing takes place, the buyer, the seller, the agents, the lender and others, such as relocation companies, have differing interests to protect. These competing interests necessitate a knowledgable third party who can conduct an accurate, reliable radon measurement - a third party that has responsibilities to a client, and concerns for professional liability in their actions.

A good radon test is an accurate, reproducible indication of the potential for elevated radon concentrations in a home, school or commercial structure.

In order to conduct a good test, someone needs to do the following:
- determine the appropriate testing strategy for the type of building
- select the right location in the building
- know how to deploy and operate the device used
- know how the device is analyzed to measure radon
- control and monitor the conditions under which the test is conducted
- record and document necessary information so interpretation and comparison can be made
- and, report and interpret the results and EPA guidelines to the various parties involved

That someone needs to know what they are doing. Charges for radon testing services range from $75 to $250.

In order to fix buildings with radon problems, someone needs do the following:
- understand why a building has a radon problem
- determine whether the measurements made are valid and support the decision to fix the problem
- know how to determine the most effective radon reduction method to use
- know how to install a safe, effective system that does not violate existing building systems
- and, be able to meet building codes and worker safety requirements

Senate PH&W
Attachment #5
2-23-93

That someone needs to know what they are doing. Costs to fix a home, and most any home can be fixed, range from $500 to $2500.

What adds to the complexity and challenge of this is the nature of radon. Rated a Class A carcinogen by the EPA, it is an odorless, colorless, tasteless, naturally occurring radioactive gas which is the second leading cause of lung cancer. The Surgeon General, the American Lung Association, the American Public Health Association, and the American Medical Association all consider indoor radon a national health problem. The only way we can know how much of the gas is present is by testing for it. We must rely on the knowledge, expertise and credibility of others in order to interpret our risk.

The EPA has two voluntary quality assurance programs - one for testers and one for contractors, both with protocols and standards that, if followed, help the public get reliable services. These programs are a logical structure on which to build a Kansas regulatory program.

Through an effort supported by the EPA, Kansas State University provides training and exams for these two programs in a consortium serving twelve midwestern states. The program costs for participants range from $400 to $1000. Qualifying individuals have identification badges, can advertize as "meeting EPA requirements" and are put on lists distributed to state health departments by EPA. Many participants maintain listings for both programs and offer a combination of services. Individuals that meet these qualifications can both test and fix reliably, and this is important in a state with large rural areas with limited access to services. While no one is getting rich in the radon business, I believe the costs of demonstrating proficiency and meeting the standards of these federal programs are not overly burdensome.

I believe there are many precedents for government regulation to aid in protecting consumers regarding health issues. This committee may consider legislation which regulates activities involving environmental tobacco smoke, an EPA estimated cause of 3,000 lung cancer deaths per year in the United States. With one percent of the US population in Kansas, that could be translated to 30 Kansas deaths per year.

You and I can at least perceive that hazard and take steps to limit our exposure. Please consider supporting legislation which would regulate activities involving radon, an estimated cause of 14,000 lung cancer deaths per year. With one percent of the US population, that would translate to 140 Kansas deaths per year due to radon.

Radon is a hazard which is imperceptible, and whose ill effect is actually multiplied in the presence of tobacco smoke. I believe a minimum program of requirements for those who work with radon is a wise investment in protecting the public health and welfare. Please support this legislation. Thank you for your time.

RMD
RADON MEASUREMENT
& DIAGNOSTICS

23 February, 1993

Testimony given before Senate Committee on Public Health and Welfare regarding Senate Bill SB 311.

Thank you Chairperson Praeger and members of the committee. My name is Stephen E. Albright. I'm in the radon measurement and mitigation industry and participate in both EPA radon programs.

I've got some unpleasant news. Your house has a bad habit. It smokes. And it can't quit without your help. Maybe it doesn't smoke much. Maybe it's got a four-pack a day habit. You don't know how serious the problem is but it's time you found out.

Of course, your house doesn't actually light up. What it's puffing is radon gas. The way radon gets into a house is a lot like how smoke gets in your lungs. It works this way: A house inhales radon from the earth. Every house. Every school. Every workplace. They all inhale radon. The question is how much.

Of course, if you're like most of us, you'll think, "Not my house. My house'd never do anything like that." So you ignore the situation. And your family experiences the negative health effects caused by exposure to radon.

Maybe you're asking yourself, What's the connection? Why compare radon to smoking? Good questions. Fact is, environmental tobacco smoke has recently been upgraded by the EPA to the status of radon gas. Today, both are Class A carcinogens, known human killers. In sufficient quantity and over time, both cause lung cancer. And when you put the two together, the effect is synergistic.

There are other similarities between environmental tobacco smoke and radon, but here's the big difference. Smoke lets you know it's there. With radon, there's no physical way to detect its presence. Here's a second important distinction. You can eliminate environmental tobacco smoke by decree. Just tell people, "Not in my house." Radon's more involved.

You start with a short-term — 2 to 7 days — radon test; EPA has developed specific protocols for this. Usually, the test is the only information used to determine whether to take further action. Therefore, adherence to the test protocols is crucial in generating high-quality information. If test results are below the action level, you breathe easy. If elevated radon levels are confirmed, things get more complicated. The condition won't go away without help.

Long-term radon reduction requires knowledge and skills. Understanding radon transport under different operating circumstances and in different structures is essential in lowering radon concentrations in cost-effective ways. Again, the EPA has mitigation standards. The goal is not only to reduce radon concentrations, but also to ensure that no structural or mechanical systems suffer as a result.

P.O. BOX 1602
LAWRENCE, KS 66044
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Senate P H&W
Attachment 6
2-23-93

An oversight in the mitigation process can cause a gas furnace or water heater to backdraft deadly carbon monoxide gas! As I say, things get complicated.

There are good people in this industry and there are bad. That's a problem.

I believe Senate Bill 311 will give some assurance to the consuming public that the radon industry is reliable, accurate and professional. That's why I urge you to pass this bill to the full Senate with strong committee recommendation.

Thank you,

Stephen E. Albright
President, Radon Measurement & Diagnostics, Inc.

Midwest Radon
5005 W. 129 terr. Olathe, KS. 66061
(913) 780-2000
EPA Approved Contractor # 10510. EPA Listed for Primary Testing that "Meets EPA Requirements"

Testimony RE: SB# 311 (Committee of Public Health)

Why do we need a Radon Program in Kansas?

My Name is Gary Hodgden. I've been dealing with radon since 1987 and my family has provided Home Inspection and Repairs services since 1976.

I'm here to give you a taste of what <u>really</u> goes on out there.

Lets first look at Radon Testing:

20-30 people in the WHOLE STATE OF KANSAS are EPA listed and trained.

IN KANSAS CITY ALONE there are more than <u>60 unlisted - untrained firms</u> providing "test services" .

<u>Effects on Consumers?:</u> POOR testing procedures. POOR reliability.

"False high results" of course cause unneeded repairs

but more often....

"False low results" leave people unknowingly at risk.

Often no booklets, no health risk data, and not even the EPA Closed House Protocol test instructions are provided.

SOME REAL LIFE EXAMPLES:

•Two different firms have told me they had never had a high reading after hundreds of tests. This is a 'statistical impossibility' in our area (with proper test procedures).

•Another confessed after getting his first real high reading of 64 pCi/L, "I finally realized I was supposed to tell them to close all of the windows". Twice, I've seen companies actually recommend open windows during the test.

•One local "test kit" laboratory's poor quality may explain why they are not EPA listed. But hey, they still legally sell those kits.

<u>Effects on the Testing Industry?:</u>

Consumers shop <u>price</u> rather than understanding quality differences.

•We lose business if we charge more for expertise, equipment and training.

Average test in KC by <u>untrained</u> firm = $75

Average <u>trained</u> test by EPA listed firm = $85

Senate PH&W
Attachment # 7
2-23-93

•We lose referrals when quality test procedures discover high radon or cheating. Test cheating in home sales is attempted more than 30% of the time.

Effects on State and Federal programs?:

"Why should I spend $400-500.00 to get Radon Measurement training when there is no law against it". Some firms make a few thousand bucks a month from testing and who can blame them! You almost have to take a few days out for training to pass the EPA exams.

BOTTOM LINE: I know about 50 inspectors on a first name basis. Though good people, they're are not going to jump through the hoops of Radon training unless they're required to.

Now, Lets look at Radon Mitigation

(Every handyman or construction tradesman "knows it all" about radon.)

Effects on Consumers: (REAL LIFE EXAMPLES)

•A homeowner spent $1800.00 with a handyman before calling an EPA approved contractor. *Typical local cost for system that fixed it is less than $800.00.*

•A home builder installed an large exhaust fan. Radon levels went up and the furnace backdrafted.

•One firm sold indoor fan systems that EPA has determined to be dangerous (but are much cheaper). Contractors providing correct systems suddenly appear to be price gougers. We now see home builders and handymen installing these indoor systems. Approved EPA contractors can lose their badge but no law can stop the handyman, the homebuilder or anyone else from doing this sort of thing. We've seen; Fans blowing concentrated radon into the home, potent exhaust pipes dangerously placed next to a complete wall of windows and sliding glass doors, you name it ... we've seen it.

Effects on the mitigation Industry:

Several "Trained and conscientious Companies" are out of business. The typical prices in our area fall significantly below most comparable construction work. Many companies can't make enough to afford basic business essentials like

liability insurance.

Believe me, if you think people suspect being overcharged by car repairmen, or a lawyer .... try walking in as a radon repair man.

Effects on State and Federal programs:

And once again, "Why shell out $600-900.00 in Radon Reduction training when there is no law against it".

Radon in general:

Often said, "If the government doesn't think its a big enough deal to require action, why should I have to fix it?" Most people hardly know what radon is. Media coverage is confusing (at best). Professionals such as realtors and home builders often poo-paw the issue. The Homebuilder's Association has guidelines for preventing radon problems during construction at a minimal cost. Realtor and Home Builder training programs are available but.... no one signs up.

Effects on Consumers: (REAL LIFE EXAMPLES)

•I have been in whole neighborhoods that average 50-150 pCi/L. *This is serious stuff.* I have had it said, "Oh, my house tested 50 and the one next door was 70. I guess thats pretty normal. No big deal, huh. "

•I have been in a home where two boys had slept in a 35 pCi/L basement for all of their 10 years. The health statistics rightfully scared the mother to death. She asked, "Why didn't someone tell us theres a problem around here? How often should I get chest X-rays? Have they tested the school (a block away)?" There was very little I could say that was comforting.

My Conclusion:

Seems like a simple concept: If your providing the service, you should get some training.

Almost any State supported program would be a step forward and would have widespread, astounding positive effects. I strongly urge you to support this legislation.

Testimony RE: SB# 311 (Committee of Public Health)

More about Gary Hodgden: Through 1991, the president of the Society of Professional Property Inspectors in Kansas City. A member of the national and the local "Region 7" chapter of the American Association of Radon Scientists and Technologist as well as a member of the Conference of Radiation Control Program Directors, Inc. Has provided symposium style training for the American Society of Home Inspectors. Has received recognition for outstanding contributions in innovative mitigation design by the Association of Energy Engineers. Aids the Regional training centers in Radon Training. Participating in data acquisition with the EPA SEP (School Evaluation Program) and other programs.

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

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ATTORNEY GENERAL

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Testimony of
Deputy Attorney General, Theresa Marcel Nuckolls
On Behalf of Attorney General Robert T. Stephan
Before the Senate Committee on Public Health and Welfare
RE: 1993 Senate Bill No. 311

February 23, 1993

Madam Chair and Members of the Committee:

Thank you for the opportunity to appear on behalf of Attorney General Stephan. Attorney General Stephan supports Senate Bill 311 as a means of protecting Kansas citizens against unscrupulous persons who are not qualified to provide the service they perform. The Kansas Consumer Protection Act offers some measure of recourse should a deceptive or unconscionable act occur in connection with a consumer transaction involving a radon test. However, the provisions of Senate Bill 311 will hopefully create additional consumer protections.

Pursuant to this bill, persons performing the tests must qualify for certification; those who are not certified risk imposition of the penalties set forth at new section 7 of this bill.

In 1990 this office filed a lawsuit against a Florida company selling home radon gas detectors in Kansas. The company in question ultimately entered into a consent judgment. However, this company and others used fear as a selling point and implied that their tests alone could "save" the buyer from harm. While a certification program may not entirely prevent abuse of such authority, we believe that EPA training and certification will help to genuinely provide buyers with some degree of protection.

We encourage your favorable action on this bill.

Senate PHEW
Attachment # 8
2-23-93

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

Robert C. Harder, Secretary

Reply to:

Testimony presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

Senate Bill 311

Passage of S.B. 311 would require the Secretary of KDHE to establish a certification program for persons performing radon testing and mitigation in Kansas and to promulgate rules and regulations for the implementation and administration of the program. The Secretary would be authorized to establish a fee schedule to defray all or part of the costs of the program and the Radon Certification Fee Fund would be created.

A very important provision of S.B. 311 would require radon testers and mitigators to report the results of their testing and mitigation in Kansas to KDHE and would provide for confidentiality of the data and information received. It appears there is a significant amount of radon testing and mitigation that has been and continues to be performed in Kansas. The data and information obtained from these efforts would be extremely valuable to KDHE in assessing the risks associated with indoor radon in Kansas and developing long-term plans.

Because radon gas is colorless, odorless, tasteless, and otherwise undetectable except with specialized equipment or test kits, the opportunity for individuals to be taken advantage of relative to radon testing and mitigation is great. This is why a number of states have already passed similar legislation.

Although we do not have exact numbers, there are a significant number of radon measurements and mitigations performed in Kansas each year. We currently have results from approximately 8,000 indoor radon measurements already performed in Kansas. Radon measurements, and mitigation if screening measurements are greater

Senate PH&W
Attachment #9
2-23-93

Mills Building • 109 SW 9th • Topeka, Kansas 66612-1228 • (913) 296-1500

than 4 pCi/l, are required for virtually all read estate transactions involving relocation companies. Radon measurements are also more commonly being requested as part of routine real estate transactions and federal legislation has been introduced which would require disclosure of radon information at the time of all real estate transactions involving federal assistance.

There are currently no standards or requirements for persons performing radon measurements or mitigations in Kansas. Anyone can perform such.

We have received a number of complaints regarding radon measurement and mitigation companies in Kansas and believe that a significant number of radon mitigation systems have been installed in Kansas which do not comply with EPA radon mitigation protocols. We are aware of one mitigation contractor in particular who has routinely installed radon mitigation systems that are contrary to EPA mitigation protocols. Some of these systems have the potential for actually producing greatly elevated indoor radon levels under certain circumstances. However, we are unable to do anything about it.

It is intended that the provisions of this bill be implemented without initiating a major new regulatory program. Kansas State University is part of a consortium which has been selected and funded as one of four EPA Regional Radon Training Centers in the United States. As such KSU administers EPA's Radon Contractor Proficiency Program (RCP) for this region. This involves training as well as administering the National Radon Contractor Proficiency Exam. All records pertaining to these training and examination efforts are maintained at KSU. However, participation in this program is strictly voluntary and many persons performing radon mitigation do not participate. It is anticipated that under this proposed legislation, the requirements for certification of radon mitigators in Kansas will be the satisfactory completion of the Radon Contractor Proficiency Exam.

EPA conducts a National Radon Measurement Proficiency (RMP) Program for radon testers. In addition to demonstrating accurate measurement of radon with test kits exposed in EPA's radon chambers, testers must also have adequate quality control and quality assurance programs. Participation in this program is also voluntary and many persons performing radon testing do not participate. It is intended that the requirements for certification of radon testers in Kansas under the proposed legislation will be the satisfactory completion of EPA's RMP Program.

It is not the intent of this bill to require radon testing in Kansas; nor to require certification for individuals to test and mitigate their own home or the home of a friend or relative. It is also not intended to require certification for retail stores to sell home radon test kits from a certified supplier.

The U.S. EPA has awarded a State Indoor Radon Grant (SIRG) for Kansas to fund KDHE's radon program efforts, including funding for contractual services to be provided by KSU Engineering Extension. The purpose of the grant is to assist the State in establishing a radon program which can assess the risks associated with indoor radon in Kansas, develop a long-term action plan, and provide up-to-date guidance, information and assistance to citizens relative to radon in their homes, schools and work places. We are now in the middle of the third grant year and have already applied for the fourth year grant. Legislation is now being considered by the U.S. Congress that would provide for a continuation of the SIRG program.

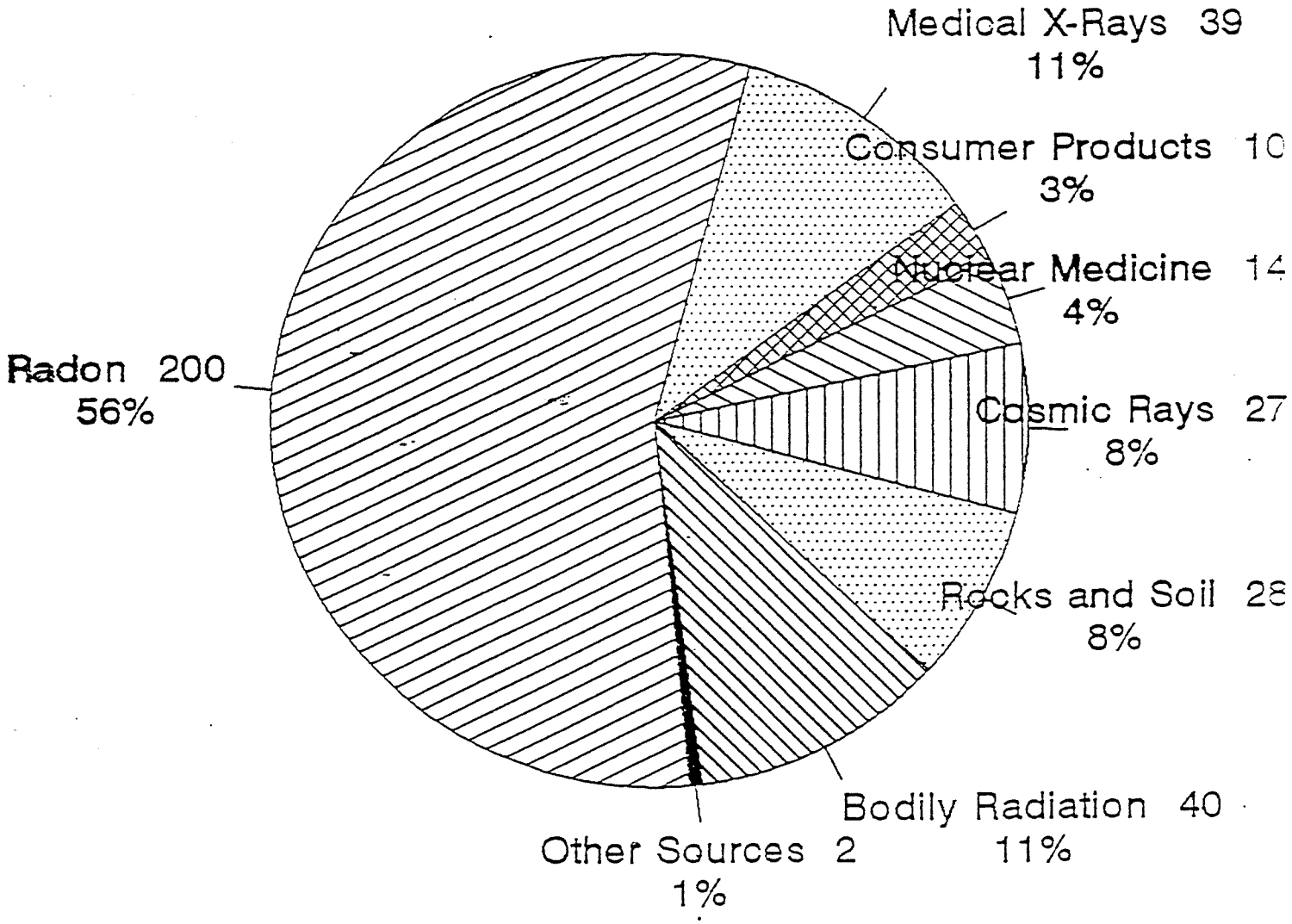
It is expected that the funding provided by the EPA grant will be adequate to cover the expected cost of implementing the Radon Certification Act. The required state match for the grant is provided by radon program efforts by existing non-SIRG staff and use of KDHE's allowable indirect costs as match. Should SIRG funding become inadequate, this bill provides the Secretary with the authority to charge fees to recover all or a portion of the costs of administering the certification program.

The Department of Health and Environment believes this effort represents the least costly means of assuring that those persons providing radon testing and mitigation services to the citizens of Kansas have the necessary knowledge, expertise and competency to perform such services. The KDHE urges favorable consideration and support of S.B. 311.

Testimony presented by: Harold Spiker
Chief, Environmental Radiation & Emergency Preparedness & Acting State Emergency Response Commission Staff Director
Bureau of Air & Radiation
February 23, 1993

RADIATION EXPOSURE TO THE AVERAGE PERSON

360 milliREM/year



SOURCES OF RADIATION EXPOSURE

Source: National Council on Radiation Protection and Measurements

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

November 15, 1991

The Honorable Jesse Helms
United States Senate
Washington, D.C. 20510

Dear Senator Helms:

I am responding to your request of October 22, 1991, to review and comment on the information submitted to your office by Mr. David A. Culver, President of Radalytic Labs, Inc. in South Carolina. Mr. Culver states that many U.S. citizens are unsuspectingly receiving a radiation dose from radon in their homes exceeding the radiation doses that the Nuclear Regulatory Commission (NRC) allows nuclear power plant workers to receive.

The NRC, under the jurisdiction of the Atomic Energy Act, sets standards for protection against radiation from source, byproduct, and special nuclear material. Radon in homes is not considered to be source, byproduct, or special nuclear material. Thus, the Environmental Protection Agency (EPA) and the states, rather than the NRC, have the regulatory responsibility over radon in homes. A copy of your letter has been referred to EPA for their response to Mr. Culver's letter to you. The EPA has established guidelines for remediation of radon concentrations in homes. However, without such remediation, exposure levels from radon can be significantly greater in enclosed spaces with poor ventilation than the exposure permitted by NRC regulations for nuclear plant workers. I have enclosed a copy of one of several EPA publications on radon reduction that are available to the public.

Sincerely,

James M. Taylor
Executive Director
for Operations

Enclosure:
As stated

95

FEBRUARY 4, 1993

MR. KHALID KALOUT
RADIATION CONTROL PROGRAM
KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
MILLS BUILDING, 109 SW 9TH
TOPEKA, KS 66612-1228

DEAR KHALID:

SEVERAL WEEKS AGO YOU CALLED ME AND REQUESTED MY ASSISTANCE IN GATHERING INFORMATION THAT WOULD BE HELPFUL TO YOU IN YOUR EFFORTS TO LOBBY FOR LEGISLATION IN THE STATE OF KANSAS TO REQUIRE CERTIFICATION OF PERSONS INVOLVED IN RADON TESTING AND/OR MITIGATION.

YOU REQUESTED THE ANSWERS TO THE FOLLOWING QUESTIONS:

1. HOW MANY COMPANIES PERFORM RADON RELATED SERVICES?
2. HOW MANY OF THESE COMPANIES ARE EPA LISTED?
3. STORIES ABOUT IMPROPER PROCEDURES BY NON-LISTED COMPANIES?

THERE ARE 5 CATEGORIES OF COMPANIES PERFORMING RADON RELATED SERVICES IN THE GREATER KANSAS CITY METROPOLITAN AREA. THE FOLLOWING ARE THOSE CATEGORIES:

1. BUILDING INSPECTION SERVICE (YELLOW PAGES LISTING)
2. RADON DETECTION, MEASUREMENT & CORRECTION (YELLOW PAGES LISTING)
3. SOCIETY OF PROFESSIONAL PROPERTY INSPECTORS (KANSAS CITY AREA MEMBERSHIP ROSTER)
4. PEST CONTOL SERVICES (YELLOW PAGES LISTING)
5. EPA RMP AND/OR RCP LIST (THESE COMPANIES WERE NOT FOUND IN THE OTHER CATEGORIES)

THE FOLLOWING INFORMATION WILL LIST EACH CATEGORY AND THE DATA ANSWERING QUESTIONS 1 AND 2:

1. BUILDING INSPECTION SERVICE
Q1. 18

9-6

Q2. 3
(83% ARE NOT EPA LISTED, 17% ARE EPA LISTED)

2. RADON DETECTION, MEASUREMENT, AND CORRECTION
Q1. 14
Q2. 8
(43% ARE NOT EPA LISTED, 57% ARE EPA LISTED)

3. SOCIETY OF PROFESSIONAL PROPERTY INSPECTORS
Q1. 7
Q2. 0
(NONE ARE EPA LISTED)

4. PEST CONTROL SERVICES
Q1. 1
Q2. 0
(NONE ARE EPA LISTED)

5. EPA RMP AND/OR RCP LISTED
Q1. 3
Q2. 3
(ALL ARE EPA LISTED)

THE FOLLOWING DATA IS THE TOTAL NUMBER OF COMPANIES FROM ALL 5 CATEGORIES:

Q1. 43
Q2. 14
(67% ARE NOT EPA LISTED, 33% ARE EPA LISTED)

INCLUDED IN OUR RESEARCH WE FOUND 7 COMPANIES WHO CLAIMED TO BE EPA LISTED BUT WERE NOT LISTED. ALSO ANOTHER IMPORTANT FACT IS THAT THERE ARE SEVERAL NATIONAL RADON TESTING COMPANIES WHO PERFORM THE MAJORITY OF RELOCATION TESTING AND THEY USE LOCAL REPRESENTATIVES WHO OFTEN HAVE NO EPA CREDENTIALS.

THE FOLLOWING INFORMATION ANSWERS QUESTION 3:

IMPROPER PLACEMENT OF TEST DEVICE INCLUDES CANNISTERS PUT ON THE FLOOR, NEAR SUMP PITS, ON TOP OF SUMP PIT LIDS, NEXT TO OUTSIDE WALLS, NEAR WINDOWS, IN FRONT OF OR HANGING FROM HVAC VENTS, NEAR OR OVER FLOOR DRAINS, IN BATHROOMS, IN KITCHENS, AND IN CRAWLSPACES. MISINFORMATION ABOUT TEST CONDITIONS, FACTS ABOUT RADON, LIKELIHOOD OF ELEVATED LEVELS, AND CORRECTIVE MEASURES. INSTALLATION OF IMPROPER MITIGATION SYSTEMS INCLUDES LOCATING THE

FAN INSIDE THE LIVING AREA OR UNDERNEATH IT, ALSO VENTING THE DISCHARGE AT THE RIM JOIST OR IN CLOSE PROXIMITY TO A WINDOW, DECK, AND DOORWAY. ON ONE OCCASION A FANTECH F-150 (NON UL LISTED) WAS DISCOVERED BURIED UNDERGROUND! FANS WIRED INTO 60 AMP BREAKERS, WIRED INTO LIGHT SWITCHES, PULL CHAIN LIGHTS, EXTENSION CORDS, AND OPEN SPLICED WIRING. ALSO ATTACHED IS A LETTER FROM AN EPA LISTED COMPANY DESCRIBING A MITIGATION SYSTEM THEY INSPECTED.

I HOPE YOU WILL FIND MY INFORMATION USEFUL AND IF I CAN BE OF ANY FURTHER ASSISTANCE PLEASE LET ME KNOW.

SINCERELY,

Randolph S. Davis

RANDOLPH S. DAVIS
PRESIDENT
HOME RADON DETECTION CO. INC.

9-8

Midwest Radon
25005 W. 129 terr. Olathe, KS. 66061
(913) 780-2000
EPA Approved Contractor # 10510. EPA Listed for Primary Testing that "Meets EPA Requirements"

FACSIMILE COVERPAGE #1 of 7 February 5, 1993

To: Khalid Kalout

KDHE Sent to Fax # 913-296-0984

RE: [redacted]

Message:

KK

Sorry for delays in my Stories you requested. As noted herein, we don't make enough money to hire other people do essential office chores.

I could not seem to put these down without writing up an entire account or opinion.

You may extract in any way you please.

I did not get into old files to pull out last years data from Albright's attempts. I expect you have that already.

Speak to you soon,
Gary Hodgden
Pres. Midwest Radon Inspection, Inc.

9-9

From Gary Hodgden, Midwest Radon (913) 780-2000

Why is certification needed in Kansas?

Even a simple State level registration/accreditation program for both Radon Testors and Radon mitigators would have an astounding Positive effect upon: Consumers, the Industry, State and Federal Health programs, and general public awareness about radon (including public confidence in a trained radon industry).

Testing:

General Facts or problems:

About 20-30 people in Kansas are EPA listed for testing.

More than 60 unlisted - untrained firms perform tests in the Kansas City Metro area alone. We see realtors, termite companies, and others performing tests.

Effects on Consumers:

POOR testing procedures and poor reliability. Consumers may get either .... "false high results" (and unnecessarily repairs) or more often.... "false low results" (and live unknowingly at risk).

It is often the case that no information is provided with the tests: no booklets, no health risk data, no test instructions.

Cheating on radon tests in home sales is more than 30% .

REAL LIFE EXAMPLE: I know of one laboratory in Kansas City where my own quality control check on their canisters was awful. I expect they failed RMP standards and are not listed. I am told they have a long file at the Attorney General's office. They still sell canisters. They still sell mitigations.

REAL LIFE EXAMPLES: Two different untrained inspectors have told me they had never had a high reading after a hundred tests. This is a statistical impossibility in our area with proper test procedures.

Another said "I finally realized after all these hundreds of tests that your supposed to close the windows".

Twice, another test company recommended open windows during the test.

Test devices have been found to have been placed on sumps, in sumps, on retaining walls,etc. False high readings definitely resulted.

REAL LIFE EXAMPLE: Confusing/bad information is provided by the testing companies regarding tests and mitigation. Typical untrained Testors advise: "My cat lives in the basement and he's still fine." "Just seal the sump and you'll be fine." Some firms are still providing report language that is seriously outdated and misleading.

REAL LIFE EXAMPLE: Testing in a vacant home to confirm a 5 pCi/L reading. The Realtor gracefully had the furnace fan running in an attempt to pressurize the walkout basement. This can alter test results in some homes. Constant furnace fan or air conditioning is not a "normal operating condition" for

an average home. Readings were 8 pCi/l during the first day. We altered the furnace setting to "normal occupied conditions". Readings climbed to well above 20 pCi/L. Winter readings could exceed 40 pCi/L. We found later our report went in a trash can.

REAL LIFE EXAMPLE: Some Realtors prefer test methods where they know the lid will be placed back on as soon as the Radon man leaves. I've been chastised for finding high radon or cheated tests , "This never happened with the canister tests". Declaring a cheated test is delicate, to say the least. "Who'll pay for another test", etc. Many legal questions quickly come to mind. We absolutely lose referrals from Realtors when this happens.

Effects on Testing Industry:

The trained Radon industry is battered.

Consumers do not know which inspectors are qualified. They assume or are told that training makes no difference. Qualified people can't charge what is needed to cover their training, equipment, etc. Qualified people who charge more get a lower percentage of testing clients.

REAL LIFE EXAMPLE: Average test in KC by untrained firm = $75
Average trained test by EPA listed firm = $85

Consumers see themselves as price conscious shopping rather than understanding any quality differences.

Effects on State and Federal programs:

Training programs (even subsidized with government funds) are battered.

REAL LIFE EXAMPLE: A typical response from an untrained person is: "Why should I spend $300-500.00 to get training when there is no law against it." Some of those firms make a few thousand bucks a month in testing revenues. Who can blame them!

REAL LIFE EXAMPLE: One testor attempted to take the test without training. He is an Engineer and assumed there is not much to this Radon Stuff. He failed. He has not procured further training. He does however continue to perform tests each day.

In fact, several have participated in education and found its not as easy as "test kit instructions" to become EPA listed. They actually have to understand what they are doing.

BOTTOM LINE: When there is not even an incentive to take initial training, there is certainly no incentive for continued education to keep up with the changes in the industry.

Mitigation

General Facts or problems:

People with no training attempt to reduce radon. New home builders are installing systems that are against EPA standards for safety. Handymen do some completely inappropriate work. Every handyman and construction tradesman thinks they "know it all" about radon.

Effects on Consumers:

REAL LIFE EXAMPLE: A homeowner spent $1800.00 with a handyman on sealing (based upon generic advise in EPA documents) before calling an EPA approved contractor.

Typical local cost for system that fixed it is less than $800.00.

REAL LIFE EXAMPLE: A home builder installed an large exhaust fan. Radon levels went up and the furnace backdrafted. If not for a well advised (and fought for) reinspection, both circumstances would have continued unchecked.

REAL LIFE EXAMPLE: Home builders install passive systems that only work in the spring weather. Some home builder supply house has published a picture of passive systems from sump to basement rim joist. They don't work. I know because I've had to remove about 12 of them.

REAL LIFE EXAMPLE: Home builders install indoor fan systems that EPA has determined to be dangerous. Approved contractors can lose their EPA approval badge if they do that. No law can stop the homebuilder or anyone else from doing so, however.

REAL LIFE EXAMPLE: Untrained mitigation firm (still active in the business) was typically installing a system based upon one generic EPA drawing of a system. We call them "octopus systems" with suction pipes everywhere. In one home, they actually caused a foundation to sink 4" from oversuction. This group of guys, who also have an unlisted testing lab, guarantee radon reductions for $1500.00. Their disclaimer left them out of the lawsuit. The realtor and seller were sued for the entire cost of the house. An engineer provided a report concluding the system had sunk the house. (A very convenient way to cover his backside. No scientific calculation was made.) This realtor will never let a system be installed in a home she sells again.

REAL LIFE EXAMPLE: A contractor fixed a 25 pCi/L house with a fan blowing lots of fresh, outside air into the basement. The owner saved only about $300 on the installation. While inspecting the home two years later I noticed new hot water heaters, plumbing lines, etc. The homeowner saved $300 on installation,,,, Probably paid $2-300 in added heating bills each year,,, and obviously froze the water systems in the basement requiring an expected $1000 in repairs. (some savings!)

REAL LIFE EXAMPLE: Some idiot dangerously placed the exhaust out next to a complete wall of windows and sliding glass doors when initial tests indicated above 35 pCi/l.

REAL LIFE EXAMPLE: The system is to be labeled as per EPA Standards.

We've seen damaged pipes, fans that have fallen loose blowing radon into the basement, and even been called by puzzled plumbers who tried to add sewer lines to them.

REAL LIFE EXAMPLE: During rains this year and a few years back, several home sales were lost due to closed sump covers. Flooding was occurring in basement and inspectors can not legally open sump lid to inspect: sump drainage, pump operation, nature of sump system, etc. We highly recommend that a clear cover or one with some visibility be used in order to provide future homeowners with ability to monitor sump conditions.

Effects on the mitigation Industry:

The industry is battered. Several "Trained and conscientious Companies" have gone out of business.

FACT: The typical prices in our area fall significantly below most construction work. Even so, people feel they are getting ripped off. Many companies can not make enough profit to afford liability insurance or other business essentials.

I've met people who feel $25 is too much to ask for fixing radon. People hear so much wrong information they assume you are a rip off artist.

Another resulting problem: The less scrupulous (though trained) people in the field actually have mislead the consumer or perform less than adequate jobs to gain the little available work.

REAL LIFE EXAMPLE: Before EPA Interim Standards for systems existed, there were EPA guidelines for the systems. One firm offered systems directly against the guidelines right up until the Standards were implemented. This allowed repair costs at substantially lower rates. Those contractors trying to provide correct installations were touted as frauds for charging more. One firm went out of business due to trying to compete with this unfair business practice.

REAL LIFE EXAMPLE: In winter time we have for several years seen **out of work contractors** enter the field to keep payrolls going. There are some very unfortunate systems being installed due to this. It is difficult to compete with continued **sub-standard** installations that are hundreds of dollars cheaper. Once again, the "trained and conscientious Companies" appear to be price gouging for no reason.

Effects on State and Federal programs:

Training programs are battered.

The industry feels they are taxed enough and get no work. They are angry about taking continuing education that they seriously need.

FACT: Once again, 'why pay out $600-900.00 in training when there is no law against it".

Radon in general:

General Facts or problems:

Media coverage has been minimal. I believe people complain about it. People seem to believe the 1 death in 2 million from "low-cal sweeteners" is the same risk as the 1 death in 17 thousand that radon produces each year.

FACT: Our 4 State region has the highest radon incident in the country.

FACT: EPA, the Kansas Health Department, the US Surgeon General and most respectable health organization agree that radon is a serious risk. In fact it may be concluded from EPA statistics that 50-210 people in the Kansas City area die each year from radon exposure (with an average expected at 98 deaths). This is roughly 4 times the "second hand smoke" statistics. Radon death expectations by far outweigh any other air quality, hazardous material or radiation risk that EPA deals with. 1 person in a family of 4 will be expected to die of cancer within 10 yrs @200 pCi/l daily exposure.

Governments took 20 years to put Smoking Warnings on cigarette packs only after incontestable evidence of 20 years of surveys existed. Its still being debated.

Effects on Consumers:

REAL LIFE EXAMPLE: I've seen an attorney for the National Home Builders talking about how safe our area is. As stated, our 4 State region has the highest radon incident in the country.

REAL LIFE EXAMPLE: I have been in neighborhoods that average 50-150 pCi/L. These are not high real estate sales markets and testing is rare because of homeowner apathy. I have had it said, "Oh, my house tested 50 pCi/L and the one next door was 70 pCi/L. Thats no big deal." This is frightening.

REAL LIFE EXAMPLE: I have been in a home where the children slept in a 35 pCi/L basement for 10 years. The mother never thought about testing. The statistics rightfully scared her to death. She said, "Why didn't someone tell us. Have they tested the school (a block away)." There is very little I could say that was comforting.

FACT: A new homeowner will almost never know the ramifications of the radon activity that took place in his home. I doubt any homeowner will retest his home when he was sold a supposedly "radon free" home. Suggestions to test as per EPA guidance seem to fall on ears that suspect your motives for such a recommendation.

Effects on State and Federal programs:

With no legal requirements, there will be very little training occur.

REAL LIFE EXAMPLE: I know about 50 inspectors on a first name basis. They are not going to get training without being required.

REAL LIFE EXAMPLE: Though training programs are available, I doubt a single Home Builder has ever signed up. I will have a lifetime of work provided by builders who ignore Radon. The National Homebuilders Association has guidelines for preventing radon problems during construction at minimal cost.

They not only never request education, they thwart the process of radon detection. They are the most firm believers that radon is a hoax.

REAL LIFE EXAMPLE: Though training programs are available, I know of no Realtors in our area who have requested this education.

Conclusion:

A simple State level registration/accreditation program for both Radon Testors and Radon mitigators would be extremely effective and is needed.

The general apathy regarding radon is to blame for most of the problems described herein. Often it is cited that "the government does not think its worth requiring action. Why should I?"

In fact, many health department officials who speak to the public are not funded properly to keep up with the lastest radon information.

Extensively restrictive legislation without enforcement capabilities could result in untrained people inheriting the market by default. (There is a vast supply of "radon experts" waiting to do the work who have read one pamphlet and know all.)

However, no program at all is a far more ominous prospect.

TO: Senate Committee on Public Health & Welfare
FROM: Mary Jo Kleiger
Kansas Homeowner
RE: Testimony on Senate Bill # 311

My husband and I moved here from Maryland, and the arrangements for buying a house were conducted long distance. We arranged to have the radon inspection done by a man on the Environmental Protection Agency's National Radon Contractor Proficiency Program list for Kansas, and had a bad experience with him. He initially found a level of 5.8 pCi/L in the basement of our Kansas house. He charged us $125.00 to cover the sump pump, and reported the post-mitigation radon level in the basement to be 3.9 pCi/L. To us, this was a "borderline" reading, since 4.0 pCi/L was considered a minimal level to which to lower indoor radon, and it was actually deemed feasible and ideal to lower indoor radon levels to below 2.0 pCi/L. We looked at all the readings he had obtained over the 48 hr. testing period, and many had been above 4.0 and had even reached as high as 6.0. We found out by calling him long distance that in his post-mitigation radon testing, he had violated standard radon measurement protocol as we understood it. That protocol calls for "closed house conditions" for 12 hours prior to any radon measurement, which means that doors and windows throughout the house should not be left open. Instead, he had fully ventilated the basement by leaving a window open, had then placed the measurement device by this window, and then had included all the initial radon measurement readings as part of the "average" he later reported to the realtor.

The mitigator then told the Sellers a different story; tried to cover his tracks by writing a second letter to the Realtor explaining how he had left the window open; but then would not change his first letter that claimed the average radon reading was 3.9pCi/L. The man was presenting himself unreliably and, as a result, the Sellers stated they would pay for no radon work. We decided to cut our losses; buy the house and fix the radon problem ourselves after we were there in person. Once in Kansas, by luck, we stumbled on a company outside the Topeka area that specialized in radon measurement & mitigation and had substantive previous experience. On their advice, we obtained our own radon readings under true closed house conditions. The basement radon readings we obtained were 7.9 and 8.6 pCi/L (this was to be the "safe" play area for our two year old son!). This second company found the original sump pump sealing work to be inadequate. They conducted special tests (which the original inspector had never suggested) to diagnose the predicted reliability of sub-slab ventilation on our particular house. And they discovered a crawl space opening in the basement that was providing a substantive radon influx as well. Their cost estimate of the sub-slab ventilation work was 2 1/2 times what the original mitigator had estimated that work to cost. However, they guaranteed, in writing, sufficiently lowered radon levels. Two men worked two full days to finish the mitigation work. The cost was clearly equal to the amount of time they spent (and now we wonder what work the original mitigator would have done for the fee he was charging). Most important, they lowered the basement readings to an average of 1.0 pCi/L and the readings in my son's bedroom to 0.5 pCi/L.

I have agreed to testify in front of your committee because, as a consumer, I felt inadequately protected and guided in this process. There seemed to be no reliable Proficiency standards for radon inspectors and mitigators that we could use at a geographical distance to help select adequate service people in this area. It was by sheer luck that we found the Company we were later satisfied with. Thus, any means by which your committee could establish tighter regulation and/or licensing standards on what we believe to be an important service with established health hazard implications would be greatly appreciated. Thank you.

Senate PH&W
Attachment #10
2-23-93

SB308
February 23,1993
Carol Macdonald, Administrative Secretary
Kansas Dental Board

Remarks from Dr. Estel Landreth
President, Kansas Dental Board

KSA 65-1455 C (1) and (2) outline the educational requirements for dental hygienists, highly trained and licensed dental professionals. The Kansas Dental Association has adopted policies that would allow untrained, unlicensed personnel to perform procedures that currently require accreditied training and licensure. Kansas has two accreditied dental hygiene schools. The majority of the board support education and licensure of dental hygienists to ensure continued quality of care.

The issue of administration of local anesthetic by a hygienist is found in amended KSA65-1456 (d) (1). The Kansas Dental Board is currently in the process of adopting rules and regulations which would allow this. The public hearing on this issue will be held March 10 in Emporia.

One of the main issues of this legislation is general supervision. This would allow a hygienist to perform routine hygiene services without the presence of a dentist, if the patient has been examined by a dentist within the past nine months, and the dentist has prescribed routine cleaning and preventative procedures. Last year 25 or 26 states allowed general supervision. This year the number has increased to 30, including our neighbor, Missouri. General supervision would increase access to routine preventative services in nursing homes, schools, and state institutions. Once a dentist has examined the patients and prescribed the care, a hygienist could provide frequent continued care and oral hygiene instruction over the next nine months without requiring the presence of a dentist.

This is the third year this issue has been presented. My concern is that it will be here again next year. If this bill does not go forward, the board will ask that a committee be formed to study these issues and recommend legislation.

This bill is consistent with the legislation introduced by the Dental Board last year, which passed the House and Senate but was vetoed by the Governor.

Senate B/H&W
attachment #11
2-23-93

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842-3088

TESTIMONY PRESENTED TO
THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING SB 308

February 23, 1993

Madam Chair and Members of the Committee:

Kansans for Improvement of Nursing Homes has observed over many years that there is all too often a serious lack of emphasis on oral and dental hygiene in nursing home care, to the detriment of the comfort, cleanliness, and nutrition of nursing home residents. Lack of adequate staff for daily routine care, lack of dental equipment and space in nursing facilities, and inadequate Medicaid reimbursement are some of the factors identified by dentists, hygienists, nursing homes, and consumers as contributing to the problem.

We have also observed the reluctance of many dentists to take their practice to the nursing home; the majority prefer instead that patients are brought to their offices. Many nursing home patients are so severely debilitated that transporting and treating them pose significant difficulties for the patient, the nursing home, and ultimately for the dental office staff.

We can understand the dentist's preference for performing complicated procedures in his or her own well-equipped office. However, we believe that much routine care generally performed by dental hygienists could equally well be carried out on the adult care home premises under the general supervision of the dentist who would be expected to examine the patient at reasonable intervals and to be familiar with the care needs of the patient. Further, the more frequently the dental needs of nursing home residents can be observed by a trained person better versed in oral hygiene care than are nurse aides or, in many instances, even licensed nurses, the greater the likelihood that those needs can be properly addressed. Timely routine dental care can prevent a multitude of physical ills, from extensive dental repair to nutritional deficiencies.

KINH's purpose today is to point out to you that there is, indeed, a problem of assuring adequate dental care in nursing homes and to ask your careful consideration of SB 308 as a potentially cost-effective step toward its solution.

Sandra Strand

Sandra Strand
Legislative Coordinator

Senate P H & W
attachment #2
2-23-93

KANSAS DENTAL ASSOCIATION

Statement by Scott C. Kennedy, D.D.S.
Senate Public Health and Welfare Committee
S.B. 308
February 23, 1993

Chairman Praeger and members of the Committee, I am Dr. Scott Kennedy. I am a dentist in private practice here in Topeka. I am also the President-Elect of the Kansas Dental Association. I appreciate having the opportunity to discuss with you my concerns about permitting dental hygienists to work without the on-site supervision by a dentist.

My first concern is that permitting hygienists to work without a dentist on-site is dangerous to patients. Dr. Sherwood mentioned a number of the complications that can arise in the course of a dental prophylaxis or teeth cleaning. A cleaning is not a simple procedure. As a matter of fact, it can be one of the more traumatic procedures in dentistry. Medically compromised patients -- such as the elderly patient with multiple diseases like heart disease, diabetes, hypertension -- need the highest level of care from the most highly qualified provider, the dentist.

Secondly, access to care will not be affected by this legislation. We see, for example, that in states where hygienists can work without dental supervision in nursing homes, they choose not to do so. A 1987 survey of nursing homes in Washington State showed that of 200 nursing homes surveyed, only two of the facilities had a hygienist working on-site.

The major roadblock to greater access to dental care for nursing home residents is funding. The problem is not for the private pay patients, but rather for the more than 50 percent of residents who are Medicaid clients. Without an adequately funded adult Medicaid program Medicaid clients will have problems with access to care -- with or without this legislation.

There is simply no way that volunteer dentists or hygienists can provide care to all patients in need. This bill represents a simple and wrong solution to the complex problem of oral health care in nursing homes.

I treat nursing home residents and serve as a consultant dentist for two nursing homes. I treat patients in my office whenever possible, because I have needed equipment to provide the highest quality care.

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Senate PH&W
Attachment #13
2-23-93

I treat nursing home residents and serve as a consultant dentist for two nursing homes. I treat patients in my office whenever possible, because I have needed equipment to provide the highest quality care. I treat patients in the facility when the patient cannot be transported to my office. Treating patients in the average nursing home is a challenge for a dentist. There is no equipment to suction the mouth, no drill and inadequate lighting. The quality of treatment suffers due to the inadequacy of the environment.

Given the stringent infection requirements mandated by OSHA and the Centers for Disease Control, there is absolutely no way that I could permit a hygienist I employee to work in nursing homes. As an employer, I am obligated by law to see that my employees work in a setting that meets very strict infection control standards. I have the same obligation to the patients who are being treated.

This proposal, therefore, will affect only the very few retirement community in Kansas that have dental operatories and those tend to serve the relatively affluent residents who are private pay. Residents in the average nursing home would not have their access to care increased, because the average home simply cannot afford to equip a dental operatory.

Very few nursing homes in Topeka or across Kansas have dental operatories.

I would also like to note that reducing the standard of care by permitting hygienists to work without the on-site supervision of a dentist will not have an impact on the cost of dental care. The hygienist under this bill would still be employed by the dentist, just as they are today. There is no reason to believe that fees would change

Again, I appreciate your consideration of my opposition to this bill.

KANSAS DENTAL ASSOCIATION

Statement by Cynthia Sherwood, D.D.S.
Senate Public Health and Welfare Committee
S.B. 308
February 23, 1993

Madam Chairman and members of the Committee, my name is Cynthia Sherwood, I am a dentist from Independence, Kansas. I also serve as Chairman of the Kansas Dental Association's Council on Legislation.

I appreciate the opportunity to express my opposition to Senate Bill 308. First, I oppose the bill because permitting hygienists to work without the on-site supervision of a dentist will decrease the quality of dental care the people of Kansas will receive. Second, dental hygienists do not have adequate training to evaluate, or diagnose, dental disease or develop a treatment plan. Third, access to care will not be affected.

First, unsupervised practice compromises patient care. Dental hygiene programs prepare hygienists to perform a small number of procedures involved in total patient care and to perform the procedures under the on-site supervision of a dentist. Hygienists are trained to perform valuable preventive services and instruct patients on home care techniques.

But these functions cannot be separated from total patient care. The dentist must be available during routine cleanings to examine unexpected conditions. This is especially true in the case of children and medically compromised patients.

A routine examination for children includes not only checking and assessment of the growth and development of both hard and soft tissues, including alignment, occlusion, eruption timing and sequence, harmful oral habits and intra-oral and extra-oral lesions. Hygienists are not qualified to make these assessments. One danger of general supervision is that patients and parents of patients will falsely believe that treatment by a hygienists includes these critical diagnostic services.

Medically compromised patients are at much greater risk without the dentist present. Many patients need premedication with antibiotics to have any dental procedure done.

A common complication of prophylaxis is transient bacteremia. That is, bacteria getting in the bloodstream and causing anything from a mild fever to a life threatening infection of the heart. Please keep in mind that next to a tooth extraction, prophylaxis is one of the bloodiest, most invasive procedures in dentistry. Permitting hygienists to worth on medically compromised patients, including

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Senate PH&W
Attachment #14
2-23-93

those in nursing homes, in unconscionable. Many elderly people have problems that require the skills that only a dentist can provide. The list includes bypass surgery, mitral valve prolapse, hip and knee implants, blood thinners, beta blockers and possible reactions of people who take multiple medications. You know how common all these problems are, especially with our population shift towards more and more elderly people. A patient's health history can change significantly in 9 months. A cancer that is not caught can develop into a life threatening problem. Oral cancer has a low survival rate if not detected early.

My second concern is that dental hygienists do not have adequate education to evaluate or diagnose dental disease. I have personally had both a dental hygiene education and a dental education. I graduated from dental hygiene school at W.S.U. in 1975 and worked as dental hygienist for 7 years before graduating from the UMKC School of Dentistry in 1982.

There is no comparison between the two training programs. Dental hygiene education is generally 2 years post-high school leading to an associate degree. The scope and depth of course content are college undergraduate level with basic and social science courses at the introductory survey level.

The dental hygienists' training curriculum has always been based on the assumption that a dentist will be directly responsible for the hygienist's actions and be close at hand. Dental hygiene functions are a narrow portion of comprehensive dental care.

A dentist's education, by contrast, is generally 8 years of study, 4 years of college followed by 4 years of post-graduate dental education. The dental education trains us to responsibly manage the complete oral health needs of our patients. The forefront of this training is assessment of the patient's general health, oral health and dental health and diagnosis of oral disease. We are taught to interpret x-rays and other diagnostic tests and dental hygienists are not.

We have extensive training in pharmacology and therapeutics and are taught to prescribe medications. Hygienists do not have this training. Treatment planing cannot be accomplished without proper evaluation of the patient and interpretation of x-rays and other tests which dental hygienists are not trained to do.

As you may know, dentistry is a very complex science. Most dentists have 300 to 500 hours of extra advanced continuing education during the first ten years after graduation from dental school. Much of this time is spent in learning new skills in diagnosis and treatment of bone and gum disease. This is a very difficult disease to diagnose and treat. Hygienists play a valuable part in the mechanical treatment of periodontal disease, but it is necessary for the dentist to diagnose and plan the treatment for the patient.

Madam Chairman and members of the Committee, action on this legislation is not in the best interest of the people of Kansas. Current statutes better protect the public health and welfare. If dental hygienists want expanded career opportunities, they should pursue dental degree as I did.

Thank you for this opportunity to express my opposition to Senate Bill 308.