Approved 2-19-85
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Rep. Rex B. Hoy at
Chairperson

3:30 ~~a.m.~~/p.m. on Thursday, February 14, 1985 in room 521-S of the Capitol.

All members were present except:

Committee staff present:

Melinda Hansen, Research Department
Emalene Correll, Research Department
Gordon Self, Revisor's Office
Helen Carlson, Secretary

Conferees appearing before the committee:

Mr. Ron Todd, Insurance Dept.
Mr. Jack Roberts, Blue Cross-Blue Shield

Mr. Roberts appeared before the Committee saying he had a few comments to make on HB 2167. He stated he feels it is social legislation and would result in an increase for all paying health insurance coverage; it is unknown how many people it willl affect; affordability will be a problem; it would have to be subsidized by those paying for insurance; self-insurers would be exempt, therefore, providing more incentive to self-insure; and finally, little groups and individuals end up "Holding the Bag". Mr. Roberts passed out a booklet and explained exhibits 1 through 17, which substantiated his above comments. (Attachment I).
(Attach. II-Health Ins. Options for Uninsurables from Leg. Research)
The Chairman said Ms. Correll worked with the Interim Committee that studied this plan and he asked her to present some of her findings. She said she had contacted most of the states that had a similar bill and got the following information:

Florida - 387 people in cluded in pool since Dec., 1983; no information regarding offset in premium tax; have a one year waiting period on pre-existing conditions; most people in pool are in their 40's.
Indiana - 3,510 in pool; approx. $145,000 in premiums, approx. $217,000 paid out; have cap of 150% of standard premium.
Minnesota - 8,796 insured through pool; receive 100 applicants a week; conditions for people coming into pool are mainly alcohol, nervous and mental; approximately $4 million in premiums and $9 million in claims which are offset by premium tax.
Wisconsin - No offset against premium tax; most people in pool for nervous, mental and circulatory problems.

HB 2168 - Ms. Hansen said the bill defines a "fraudulent insurance act" and would provide immunity from civil liability arising out of the reporting of possible insurance fraud situation. In addition, the bill would protect insurance department personnel from civil liability related to their publishing of reports and bulletins disseminated as part of the department's official activities. Immunity would not apply in cases of malice or bad faith.

Mr. Todd stated the above bill was well outlined by Ms. Hansen.

HB 2171 - Ms. Hansen said this bill would add specific requirements concerning the provisions of a letter of credit used by a domestic insurer in order to take reserve credit for business transferred to a non-authorized insurer. The new conditions would require initial issuance of the letter of credit for at least one year. The letter would, by its own terms, automatically be renewed for an additional one year unless 30 days notice of intent not to renew is given. In addition, the bill would require certain provisions

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

that are already statutorily required (namely, an insolvency clause and a cancellation provision) to be expressly stated in the reinsurance agreement.

Mr. Todd stated the bill is not as complicated as it appears and applies to domestic insurance companies. He said the law now reads that you can reinsure with companies admitted in the state, and if you do they get credit for reserve. The new conditions would require initial issuance of the letter of credit for at least one year.

The minutes of February 13, 1985, were approved.

Meeting adjourned at 4:30 PM

Rex B Hoy

GUEST LIST

COMMITTEE: House Insurance DATE: 2-14-85

NAME	ADDRESS	COMPANY/ORGANIZATION
Ron Todd	Topeka	Ins dept
Lee WRIGHT	MISSION	FARMERS GROUP

2-14-85
Attachment I

HOUSE INSURANCE COMMITTEE

February 13, 1985

House Bill 2167 -- Mandatory Health Insurance Risk Sharing Plan.

- Social Legislation (which will most likely result in an increase to all those now paying for health insurance coverage).

- Really don't know how many it will affect. (A recent study in Minnesota showed 1 in 12 without health insurance coverage or about 8 1/3%.)

- "Affordability" will be a "problem".

- We would expect losses to exceed income, therefore requiring that it be subsidized by those who are paying for insurance.

- Mandates always increase costs.

- ERISA exempts self-insurers from state mandates thus providing an incentive to self-insure.

- Little groups and individuals end up "Holding the Bag".

- C.O.I.L. model provides premium tax offset against losses.

Blue Cross and Blue Shield of Kansas, Inc.

Attachment I

Table 1
Persons with and without health insurance:
Percent distribution by selected population characteristics
(NMCES: United States, 1977. First household interview)

Population Characteristics		Population in thousands	Total	Without insurance coverage		With insurance coverage	
				Percent distribution (with standard errors)			
	Total	211,513	100.0	12.6	(0.4)	87.4	(0.4)
Age	Less than 6 years	18,283	100.0	12.4	(0.9)	87.6	(0.9)
	6–17 years	46,525	100.0	12.5	(0.7)	87.6	(0.7)
	18–24 years	26,616	100.0	21.9	(0.8)	78.1	(0.8)
	25–54 years	77,969	100.0	12.1	(0.4)	87.9	(0.4)
	55–64 years	20,049	100.0	11.2	(0.6)	88.8	(0.6)
	65 years or older	22,070	100.0	4.3	(0.4)	95.7	(0.4)
Sex	Male	102,084	100.0	13.2	(0.5)	86.8	(0.5)
	Female	109,429	100.0	12.0	(0.4)	88.0	(0.4)
Color	White	183,467	100.0	11.7	(0.4)	88.3	(0.4)
	All other	28,046	100.0	18.1	(1.2)	81.9	(1.2)
Perceived health status	Excellent	96,630	100.0	11.1	(0.5)	88.9	(0.5)
	Good	81,906	100.0	13.1	(0.5)	86.9	(0.5)
	Fair	23,179	100.0	14.1	(0.7)	85.9	(0.7)
	Poor	7,510	100.0	13.7	(1.0)	86.3	(1.0)
Years of education[a]	0–11	51,245	100.0	15.5	(0.6)	84.6	(0.6)
	12	52,573	100.0	12.1	(0.4)	87.9	(0.4)
	13 or more	42,806	100.0	8.9	(0.4)	91.1	(0.4)
Place of residence	SMSA						
	Sixteen largest	54,617	100.0	10.4	(0.6)	89.6	(0.6)
	Population 500,000 or more[b]	53,667	100.0	11.9	(0.8)	88.1	(0.8)
	500,000 or less	38,352	100.0	12.2	(1.2)	87.8	(1.2)
	Not SMSA						
	Less than 60 percent rural	39,115	100.0	13.5	(1.5)	86.5	(1.5)
	60 percent or more rural	25,748	100.0	17.6	(1.2)	82.4	(1.2)
U.S. Census region	Northeast	46,940	100.0	8.3	(0.4)	91.7	(0.4)
	North Central	57,745	100.0	9.3	(0.6)	90.7	(0.6)
	South	67,371	100.0	16.2	(0.6)	83.8	(0.6)
	West	39,457	100.0	16.2	(1.4)	83.8	(1.4)

[a] Includes only those 17 years of age and older.
[b] Not included in the 16 largest standard metropolitan statistical areas (SMSAs).

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APMX

TO: ALL BLUE CROSS AND BLUE SHIELD PLANS

ATTENTION: PUBLIC RELATIONS DIRECTORS

THE BLUE CROSS AND BLUE SHIELD DIGEST

OCTOBER 22, 1980

\- 0 -

(SURVEY FINDS 12 PER CENT LACK HEALTH INSURANCE)

(WASHINGTON) -- WHILE THREE OUT OF EVERY FOUR AMERICANS SEE A DOCTOR AT LEAST ONCE A YEAR AND ONE IN 10 IS HOSPITALIZED, 26.6 MILLION AMERICANS HAVE NO INSURANCE TO PAY HEALTH CARE COSTS, ACCORDING TO A NEW GOVERNMENT STUDY.

THE ASSOCIATED PRESS REPORTED THAT PRELIMINARY RESULTS OF THE SURVEY -- SAID TO BE THE MOST COMPREHENSIVE EVER UNDERTAKEN ON A PERSONAL HEALTH CARE -- WERE TO BE RELEASED TUESDAY AT THE ANNUAL MEETING OF THE AMERICAN PUBLIC HEALTH ASSOCIATION IN DETROIT.

THE HEALTH-CARE HABITS OF 37,000 PEOPLE IN 14,000 HOSEHOLDS WERE COVERED BY THE 1977 SURVEY, WHICH WILL TAKE YEARS TO FULLY ANALYZE, THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH SAID.

THE AGNECY SAID THAT ''ONE SURPRISE'' OF THE SURVEY WAS THE LARGE NUMBER OF PERSONS WHO WERE NOT INSURED FOR HEALTH CARE. THE TOTAL REPRESENTED ABOUT

Jack

12.6 PER CENT OF THE U.S. CIVILIAN POPULATION.

THERE WAS ''NO DIFFERENCE IN INSURANCE COVERAGE BETWEEN MEN AND WOMEN, BUT THERE WAS A RACIAL DIFFERENCE,'' THE AP SAID. ABOUT 18 PER CENT OF WHITES HAD NO HEALTH INSURANCE COVERAGE, COMPARED TO 11.7 PER CENT FOR OTHER RACES. SOME OF THIS DIFFERENCE WAS ACCOUNTED FOR BY MEDICAL ASSISTANCE PROGRAMS LIKE MEDICAID THAT COVER LOW-INCOME PEOPLE, THE SURVEY SAID.

AMONG PERSONS 18 OR OLDER, ABOUT 15.5 PER CENT WITH LESS THAN 12 YEARS OF EDUCATION HAD NO INSURANCE, COMPARED WITH 8.9 PER CENT OF THOSE WITH MORE THAN 12 YEARS OF SCHOOLING.

THE SURVEY FOUND THAT MORE THAN 160 MILLION PERSONS, OR 75.9 PER CENT OF THE 1977 POPULATION, SAW/A DOCTOR AT LEAST ONCE DURING THE YEAR, WITH VISITS MORE FREQUENT AMONG WHITES THAN NONWHITES, AMONG FEMALES MORE THAN MALES, AND AMONG PERSONS OLDER THAN 65 THAN AMONG YOUNGER PERSONS.

ABOUT 65 PER CENT OF THE DOCTOR FEES, WHICH THE SURVEY FOUND AVERAGED $23 PER VISIT, WERE PAID BY FAMILIES AND INDIVIDUALS WITH PRIVATE HEALTH INSURANCE PICKING UP 15 PER CENT. THE SURVEY FOUND MEDICAID PAID ''LARGE PROPORTIONS'' DOCTOR FEES FOR LOW-INCOME PERSONS AND NON WHITES.

IN 1977, THE SURVEY SAID, ABOUT 21 MILLION PEOPLE, OR 10.3 PER CENT OF THE POPULATION, WERE HOSPITALIZED, WITH THE AVERAGE LENGTH OF STAY BEING 7.6 DAYS. ''THE OVERALL MEAN CHARGE FOR A HOSPITAL STAY IN 1977 WAS $1,127 FOR THOSE WHERE HOSPITAL CHARGES WERE KNOWN,'' THE SURVEY SAID.

PRIVATE INSURANCE PAID 53 PER CENT OF THESE CHARGES, ACCORDING TO THE SURVEY, AND MEDICAID 18 PER CENT.

#2

BCA TELECOMMUNICATIONS MTT RECEIVED MESSAGE/DATA AND ERROR REPORT

GENERAL ADM FROM BCA

1-30-85

(STUDY CHECKS OUT MINNESOTA UNINSURED)

(ST. PAUL, MINN.) -- A STUDY BY THE MINNESOTA STATE PLANNING AGENCY HAS FOUND THAT ABOUT ONE OF 12 MINNESOTA RESIDENTS HAVE NO PUBLIC OR PRIVATE HEALTH INSURANCE, AMERICAN MEDICAL NEWS REPORTED.

NEARLY ALL OF THE UNINSURED WERE INDIVIDUALS OR INFAMILIES WITH LOW INCOMES WHO COULD NOT QUALIFY FOR ANY GOVERNMENT-FINANCED HEALTH CARE COVERAGE, THE ARTICLE SAID.

ACCORDING TO THE STUDY, AUTHORED BY DARRELL SHREVE, ABOUT 54 PERCENT OF THE UNINSURED LIVE IN METROPOLITAN AREAS. A BREAKDOWN SHOWED THAT ABOUT 100,000 OF THE 342,000 UNINSURED WERE UNDER THE AGE OF 18, WHILE 80,000 WERE AGED 18 TO 24; 140,000 AGED 25 TO 54, AND 20,000 WERE 55 AND OLDER.

IN ADDITION, 31 PERCENT OF THE UNINSURED HAD INCOMES BELOW THE POVERTY LEVEL OF $4,980 FOR AND INVIVIDUAL AND $10,200 FOR A FAMILY OF FOUR, THE ARTICLE REPORTED.

THE AGENCY STUDY WAS CONDUCTED AT THE REQUEST OF A STATE SENATOR WHO CHAIRS THE MINNESOTA SENATE HEALTH AND HUMAN RESOURCES COMMITTEE AND EXPRESSED HOPE THAT THE 1985 MINNESOTA LEGISLATURE WOULD BE ABLE TO ADDRESS THE PROBLEMS OF THE UNINSURED, THE ARTICLE SAID.

#3

February 12, 1985

TO: Jack Roberts
cc: Don Lynn

FROM: Joe Kun JK

SUBJECT: SENATE BILL NO. 121
AN ACT ENACTING THE MANDATORY HEALTH INSURANCE
RISK SHARING PLAN

As you requested I've contacted the Wisconsin and Minnesota Blue Cross and Blue Shield Plans to see what the experience of their uninsured pool has been.

Minnesota - Total program loss for the last several years has been between $1.8 to $1.9 million dollars each year. After paying their share of the loss, the insurers may use this loss as a reduction to their premium taxes.

Wisconsin - Total program loss was not available, however, Blue Cross and Blue Shield United of Wisconsin's share of the loss for each year since 1981 was approximately:

1981	$ 29,500
1982	$445,200
1983	$656,000
1984	$505,000

JK:nh

505

#4

February 8, 1985

TO: Jack Roberts
cc: Joe Kun and Don Lynn

FROM: Pam Miller

SUBJECT: SB #121: RESIDUAL POOLING MECHANISM FOR THE UNINSURABLE

Shown below are ballpark rates for the scope of benefits described in SB #121, namely: $1,000 deductible per individual (limit of $2,000 per family); 80/20 coinsurance until the subscriber has paid out-of-pocket, including the deductible, $2,000 (or $4,000 per family); 60 day SNM; 30 days A/DA; $500 OP Psych; $250,000 lifetime maximum per individual.

	SINGLE	FAMILY	~~MER~~ ~~(Medicare Carve-Out)~~
Total Monthly Rate	$197.96	$300.88	~~$2.15~~

PM/pw

#5

January 16, 1985

TO: Jack Roberts
cc: Joe Kun, Don Lynn

FROM: Pam Miller

SUBJECT: INSURANCE DEPARTMENT LEGISLATIVE PROPOSAL #4 - RESIDUAL POOLING MECHANISM FOR THE UNINSURABLE

Shown below are ballpark rates for the scope of benefits described in Section 3 and the minimum level of benefits described in Section 4(d), namely, a deductible of $2,500 per individual (limit of $5,000 per family) with 80/20 coinsurance until the subscriber has paid out-of-pocket, including the deductible, $10,000 (or $20,000 per family):

	Single	Family
Total Monthly Rate	$131.31	$185.27

PM:nh

Received 9-4-84

#6

December 6, 1983

TO: Jack Roberts
cc: Don Lynn, Tom Miller, Ron Simmons, Nancy Nordberg

FROM: Rita Beckner

SUBJECT: MANDATED COVERAGES

Attached is a 1983 copy of the Mandated Coverages Report. To this year's report we have added Chronic Renal Disease, TEFRA and Licensed Social Workers expenses.

Last year Single OB and Maternity Waiting Period expenses were based on Community rates; this year, they are based on Merit Rated rates which are somewhat lower.

Overall, the grand total for 1983 is 1.6% higher than the grand total of 1982.

If you have any questions or suggestions, please let me know.

RB:nk
Attachment

Blue Cross and Blue Shield of Kansas

State Mandated Health Coverage in Kansas
Previously Enacted, Proposed Now, Possible for Future

Claims Cost to Blue Cross and Blue Shield Subscribers
1983

			Overall Dollars	Per Contract Single	Per Contract Family	Comments
A.	Chiropractors (7/1/73)	(1) BS	$2,960,288	$0.38	$2.03	Coverage became effective 7/1/73.
B.	Dentists (7/1/73)	(1*)BS	1,202,683	0.30	0.69	Dentist services already covered under Blue Shield same as M.D. prior to being mandated.
C.	Optometrists (7/1/73)	(1) BS	343,390	0.05	0.23	Eye exams had been covered by M.D.'s under Major Medical prior to being mandated.
D.	Podiatrists (7/1/73)	(1*)BS	609,414	0.13	0.37	Podiatrists services already covered under Blue Shield same as M.D.'s prior to being mandated.
E.	Newborn	(1*)BS	422,615	----	0.34	Service was already covered prior to being mandated.
	Infants (Ill Baby Care)	(1*)BC	1,218,124	----	0.98	
	(7/1/74)	Total	1,640,739		1.32	
F.	Psychologists (Direct Reimbursement) (7/1/74)	(1*)BS	263,987	0.33	0.52	Service covered (if billed by M.D.) prior to being mandated.

(1) Mandated coverage enacted.
(2) Mandated coverage proposed but not enacted.
(3) Possible future coverages for mandating.

* Benefit covered prior to being mandated.

Blue Cross and Blue Shield of Kansas

State Mandated Health Coverage in Kansas
Previously Enacted, Proposed Now, Possible for Future

Claims Cost to Blue Cross and Blue Shield Subscribers
1983

		Overall Dollars	Per Contract Single	Per Contract Family	Comments
G. Well Baby Care	(1*)BS	$ 385,325	$----	$0.31	Blue Shield coverage became effective 1/1/78; hospital services were covered prior to 1/1/78.
	(1*)BC	3,306,337	----	2.66	
	Total	3,691,662	----	2.97	
H. Obstetrical Benefits on Single Contracts	(1*)BS	874,061	0.76	----	This coverage has been available on an optional basis and rates have been approved and filed with the Insurance Department. The offering of this beneift was mandated for groups of 15 or more during 1979.
	(1*)BC	3,599,750	3.13	----	
	Total	4,473,811	3.89	----	
I. Remove OB Waiting Periods	(1) BS	1,772,245	0.19	1.25	The offering of this benefit, along with single OB coverage, was mandated for groups of 15 or more during 1979.
	(1) BC	3,005,362	0.43	2.02	
	Total	4,777,607	0.62	3.27	

(1) Mandated coverage enacted.
(2) Mandated coverage proposed but not enacted.
(3) Possible future coverages for mandating.

*Benefit covered prior to being mandated.

Blue Cross and Blue Shield of Kansas

State Mandated Health Coverage in Kansas
Previously Enacted, Proposed Now, Possible for Future

Claims Cost to Blue Cross and Blue Shield Subscribers
1983

		Overall Dollars	Per Contract Single	Per Contract Family	Comments
J. Inpatient Nervous and Mental, Chronic Alcoholism, and Drug Addiction covered same as for any other condition.	1. First 30 Days				
	(1*)BC	$6,745,974	$1.91	$3.66	House Bill 2693 requires the offering of the first 30 days of in-patient care limited to same as a daily round.
	(1*)BS (covered same as daily round)	4,806,087	1.25	2.71	
	(3) BS(psychiatric charges above daily round)	2,137,484	0.54	1.22	
	Total	13,689,545	3.70	7.59	
	2. 31 to 120 Days				
	(3*)BC	$1,453,490	0.41	0.79	
	(3*)BS(covered same as daily round	1,528,998	0.40	0.86	
	(3) BS(psychiatric charges above daily round)	691,778	0.18	0.39	
	Total	3,674,266	0.99	2.04	
K. Outpatient Psychiatric Services	(3) Basic rider (Full)	12,852,452	3.88	6.75	Assumes coverage at same level as basic coverage. House Bill 2693 requires the offering of a rider to basic which covers out-patient care for the first $100 in full, then 80% up to total payout of $500; the cost of this rider is $1,657,822.

(1) Mandated coverage enacted.
(2) Mandated coverage proposed but not enacted.
(3) Possible future coverages for mandating.

*Benefit covered prior to being mandated.

Blue Cross and Blue Shield of Kansas

State Mandated Health Coverage in Kansas
Previously Enacted, Proposed Now, Possible for Future

Claims Cost to Blue Cross and Blue Shield Subscribers
1983

			Overall Dollars	Per Contract Single	Per Contract Family	Comments
L.	House Bill 2559 Assigned Risk Pool	(2)	--------	-----	-----	Since anyone can enroll in BC and BS at any time, the only affect this would have is related to our participation in a pool of bad risks.
M.	House Bill 2270 Catastrophic coverage	(2)	**$10,287,600	$17.41	$51.35	Covers expense in excess of $5,000 per individual and $7,500 per family per 12-month period. This would primarily replace some of our present coverage. Assumes 5,000 single contracts and 15,000 family contractrs would enroll in this coverage.

(1) Mandated coverage enacted.
(2) Mandated coverage proposed but not enacted.
(3) Possible future coverages for mandating.

* Benefit covered prior to being mandated.
** A portion of these dollars would already be covered under Blue Cross and Blue Shield.

Blue Cross and Blue Shield of Kansas

State Mandated Health Coverage in Kansas
Previously Enacted, Proposed Now, Possible for Future

Claims Cost to Blue Cross and Blue Shield Subscribers
1983

			Overall Dollars	Per Contract Single	Per Contract Family	Comments
N.	Physical Therapists	(3) BS	$2,603,314	$0.61	$1.53	Initial monthly cost was provided by the Consulting Actuary.
		(3*)BC	365,463	0.08	0.22	
			2,968,777	0.69	1.75	
O.	Nurse Anesthetists	(3)	-------	----	----	Covered under current contracts.
P.	Naturopaths	(3)	UK	UK	UK	Estimate price is unknown without knowing more definitely the qualifications.
Q.	Acupuncture	(3)	-------	----	----	Unable to estimate a price without specified qualifications and treatment.
R.	Home Health Services and coverage in Hospices	(3)	$ 181,802	$0.05	$0.10	Assumes such services and facilities are available.
S.	Full coverage in State Mental Hospitals	(3) BC	3,003,632	0.85	1.63	To increase current coverage to Full for 365 days.
T.	Licensed clinical Social Workers billing without physician's referral	(1*)BS	53,208	0.04	0.13	Effective 7/1/82 Licensed Clinical Social Workers no longer need physician's referral to bill direct.

(1) Mandated coverage enacted.
(2) Mandated coverage proposed but not enacted.
(3) Possible future coverages for mandating.

* Benefit covered prior to being mandated.

Blue Cross and Blue Shield of Kansas

State Mandated Health Coverage in Kansas
Previously Enacted, Proposed Now, Possible for Future

Claims Cost to Blue Cross and Blue Shield Subscribers
1983

			Overall Dollars	Per Contract Single	Per Contract Family	Comments
U.	Chronic Renal Disease Coverage for 1st 12 months	(1) BC	$ 414,000	$2,300.00	----	Coverage effective 10/1/81.
		(1) BS	112,500	625.00	----	
		Total	526,500	2,925.00	----	
V.	TEFRA - standard group coverage (excluding Medicare) for employed persons over age 65	(1) BC	397,913	59.39	----	Coverage effective 9/1/83 for employees age 65 to 69.
		(1) BS	138,087	20.61	----	
		Total	536,000	80.00	----	
	Grand Total		67,737,363			
	Grand Total that has been Mandated or may be Mandated that was not covered prior to being Mandated					
	Including Item M		40,901,847			
	Excluding Item M		30,614,247			

(1) Mandated coverage enacted.
(2) Mandated coverage proposed but not enacted.
(3) Possible future coverages for mandating.

* Benefit covered prior to being mandated.

Exhibit A

1982 BLUE SHIELD CHIROPRACTOR

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1982 Incurred As Paid Thru 3-31-83 Single	1982 Incurred As Paid Thru 3-31-83 Family	Unpaid Factors	Estimated Incurred Single	Estimated Incurred Family
Basic	$195,966.14	$ 547,121.28	1.023	$ 200,532.15	$ 559,869.21
X-Ray	49,981.52	100,618.38	1.023	51,146.09	102,962.79
Lab	1,168.75	5,979.80	1.023	1,195.98	6,119.13
Supplemental Accident	9.60	2,753.20	1.023	9.82	2,817.35
Miscellaneous*	47,131.54	266,779.67	1.023	48,229.70	272,995.64
Major Medical	234,661.40	434,044.66	1.881	441,398.09	816,438.01
Large First-Dollar Major Medical	238,145.57	748,198.73	1.280	304,826.33	957,694.37
National Joint Major Medical	13,790.18	27,911.50	1.480	20,409.47	41,309.02
Plan 65 and Disabled	22,505.90	0	1.023	23,025.79	0
Total	$803,360.60	$2,133,407.22		$1,090,773.42	$2,760,205.52

	Si	Fa
1. 1982 Contract Months	3,281,868	1,569,286
2. 1982 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)	$ 0.33	$ 1.76
3. 1983 Projected Pure Premium (Trends = 1.155)	$ 0.38	$ 2.03

Exhibit B

Mandated Coverages (Dentists)

		Single	Family
1.	1983 rates for full prevailing Blue Shield plus out-patient X-ray	$28.87	$65.67
2.	Percent of rate applicable to dental coverage (from special study)	1.05%	1.05%
3.	Monthly rate applicable to dental coverage under basic (Line 1 x Line 2)	0.303	0.690
4.	Rounded 1983 pure premium for basic dental	$ 0.30	$ 0.69

Exhibit C

1982 BLUE SHIELD OPTOMETRISTS

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1982 Incurred As Paid Thru 3-31-83 Single	Family	Unpaid Factors	Estimated Incurred Single	Family
Basic	$ 10,754.92	$ 24,669.13	1.023	$ 11,005.51	$ 25,243.92
X-Ray	2,284.30	4,393.20	1.023	2,337.52	4,495.56
Lab	171.70	211.40	1.023	175.70	216.33
Supplemental Accident	------	------	1.023	------	------
Miscellaneous*	-144.59	12,539.31	1.023	-144.59	12,831.48
Major Medical	40,678.72	92,266.37	1.881	76,516.67	173,553.04
First-Dollar Major Medical	21,463.79	71,029.03	1.280	27,473.65	90,917.16
National Joint Major Medical	937.38	4,554.10	1.480	1,387.32	6,740.07
Plan 65 and Disabled	13,079.43	0	1.023	13,380.26	0
Total	$ 89,225.65	$ 209,662.54		$ 132,132.04	$ 313,997.56

	Si	Fa
1. 1982 Contract Months	3,281,868	1,569,286
2. 1982 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)	$ 0.04	$ 0.20
3. 1983 Projected Pure Premium (trends = 1.155)	$ 0.05	$ 0.23

Exhibit D

1982 BLUE SHIELD PODIATRISTS

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1982 Incurred As Paid Thru 3-31-83 Single	1982 Incurred As Paid Thru 3-31-83 Family	Unpaid Factors	Estimated Incurred Single	Estimated Incurred Family
Basic	$134,146.12	$ 198,968.11	1.023	$ 137,231.48	$ 203,544.38
X-Ray	21,430.73	29,270.12	1.023	21,923.64	29,943.33
Lab	2,167.68	2,474.40	1.023	2,217.54	2,531.31
Supplemental Accident	00	18.00	1.023	------	18.41
Miscellaneous*	17,614.79	122,340.78	1.023	18,019.93	125,154.62
Major Medical	6,353.42	9,582.57	1.881	11,950.78	18,024.81
Large First-Dollar Major Medical	43,962.10	90,321.82	1.280	56,271.49	115,611.93
National Joint Major Medical	562.80	1,971.09	1.480	832.94	2,917.21
Plan 65, MER, Disabled	105,270.47	0	1.023	107,691.69	0
Total	$331,508.11	$ 454,946.89		$ 356,139.49	$ 497,746.00

	Si	Fa
1. 1982 Contract Months	3,281,868	1,569,286
2. 1982 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)	$ 0.11	$ 0.32
3. 1983 Projected Pure Premium (trends = 1.155)	$ 0.13	$ 0.37

Exhibit E

Mandated Coverages (Newborn Infants - Ill Baby Care)

I. The Plans' consulting actuary assisted the Plan staff in preparing the cost estimate for ill baby care.

A. Blue Cross 1974 costs = $0.28; projected to 1983 = $0.98

B. Blue Shield 1974 costs = $0.10; projected to 1983 = $0.34

Comments: This expense is already reflected in the Blue Cross and Blue Shield experience as this has been a covered benefit for many years.

Exhibit F

- Mandated Coverages (Psychologists)

1.	Estimated 1983 cost to pay UCR benefits to psychologists versus statewide average under the basic psychiatric rider	$0.33	$0.52

Exhibit G

Mandated Coverages (Well Baby Care)

1.	Average estimated hospital charge for well baby care in 1983 at $109 per day for four days	$436.00
2.	Number of deliveries per contract month	0.0061
3.	Cost for well baby care in hospital (Line #2 X Line #1)	$2.66
4.	Average estimated physician's charge for well baby care projected to 1983	51.00
5.	Cost for well baby care for physician's services (0.0061 X $51.00)	0.31

Exhibit H

Mandated Coverages (Obstetrical Benefits on Single Contracts)

Cost for full coverage as filed with the Insurance Department:

		1983*
Blue Cross	=	$3.13
Blue Shield	=	$0.76

*With waiting period.

Exhibit I

Mandated coverages (Removal of OB Waiting Periods from OB Benefits)

Cost for removal of OB Waiting Periods as filed with the Insurance Department

	Single	Family*
Blue Cross	$0.43	$2.02
Blue Shield	$0.19	$1.25

*(all covered females including dependent daughter.)

Exhibit J

Mandated Coverages
Inpatient Nervous and Mental,
Chronic Alcoholism and Drug
Addiction (Coverage Same as for
Any Other Condition)

		Single	Family
Blue Cross			
1.	Projected Blue Cross claims expense per contract month for 30 days nervous and mental, drug addiction, and chronic alcoholism (from special nervous and mental study)	$1.91	$3.66
2.	Projected Blue Cross claims expense per contract month for 60 days at full payment plus 60 days at 50% payment for nervous and mental, drug addiction and chronic alcoholism (from special nervous and mental study)	2.32	4.45
3.	Extension of days from 30 to 120 for Blue Cross (Line #2 - Line #1)	0.41	0.79
4.	Percent 30 days nervous and mental, chronic alcoholism and drug addiction expense is of 120 days nervous and mental, chronic alcoholism and drug addiction (Based on 120 days paid at 100%)	75.8%	75.9%
Blue Shield			
5.	Estimated additional Blue Shield claims expense for 60 days at full payment plus 60 days at 50% payment for nervous and mental, chronic alcoholism and drug addiction based on projected claims expense of 1983 filed rate	$1.65	$3.57
6.	Estimated 1983 Blue Shield expense for 30 nervous and mental, chronic alcoholism and drug addiction visits limited to range maximum for medical visits. Assumes percent to decrease visits from 120 to 30 in Blue Shield is equal to Blue Cross decrease in days (Line #4 X Line #5)	1.25	2.71
7.	Extension of days from 30 to 120 for Blue Shield (Line #5 - Line #6)	0.40	0.86
8.	Psychiatric charges above daily round for 30 days based on 1983 filed rate	0.54	1.22
9.	Psychiatric charges above daily round for 30 to 120 days based on 1983 filed rate	0.18	0.39

Exhibit K

Mandated Coverages (Outpatient Psychiatric Services)

		Single	Family
1.	Estimated 1983 additional cost to cover outpatient nervous and mental, chronic alcoholism and drug addiction at the same level as basic Blue Shield benefits	$3.88	$6.75

Exhibit L

Mandated Coverages (Assigned Risk Pool, House Bill 2559)

This bill may add very little additional expense since any Subscriber can enroll in Blue Cross and Blue Shield currently, regardless of his health status.

If this program should require the removal of all ridered health statement, then the expense of the direct enrolled may approach the expense of the non-group convversions.

Exhibit M

Mandated Coverages (Catastrophic Coverage, Housebill #2270)

1. Percent of covered benefits in excess of $5,000 per individual or $7,500 per family per contract period of 12 months with a three-month carryover provision.

2. Estimated cost per contract month in 1983:

Single	=	$17.41
Family	=	$51.35

Comment: These rates are approximately 50% higher than group rates due to the potential adverse selection.

Exhibit N

Mandated Coverages (Physical Therapists)

		Single	Family
1.	Rates provided by our consulting actuary to cover out-patient physical therapy projected to 1983	$0.61	$1.53
2.	Rates approved and filed for in-patient physical therapy projected to 1983	0.08	0.22

Exhibit O

Mandated Coverages (Nurse Anesthetists)

Assumes little additional cost since benefit is currently available when billed by a physician.

Exhibit P

Mandated Coverages (Naturopath)

Until such time as it is more definite who will qualify as a naturopath, we are unable to price this benefit.

Exhibit Q

Mandated Coverages (Acupuncture)

Appears to be too new and not enough physicians trained to inpact on the overall experience enough to justify an additional rate increment.

Exhibit R

Mandated Coverages (Home Health Services and Hospices)

	Single	Family
Estimated cost per contract month in 1983. Based on Home Health Agency experiments.	$0.05	$0.10

Exhibit S

Mandated Coverages (Full Coverage in State Mental Hospitals)

		Single	Family
1.	Current rate filed with Insurance Department for full payment of charges for first 60 days and 50% payment of charges for remaining 305 days	$1.07	$2.05
2.	Current rate filed with Insurance Department for full payment of charges for first 60 days only	0.22	0.42
3.	Additional rate needed to increase coverage of remaining 305 days to full	0.85	1.63
4.	Rate needed for full coverage for 365 days (Line #1 + #3)	1.92	3.68

Exhibit T

Mandated Coverages (Licensed Clinical Social Workers Billing Without Physician's Referral)

1.	Percent increase in Social Workers services attributable to removal of physician's referral restriction (from special study of 10/83)	15%
2.	Projected Social Workers Services for 1983	14,367
3.	Projected cost per service for Social Workers for 1983	$24.69
4.	Projected 1983 increase in cost for Social Workers services due to Mandate (Line #2 X Line #1 X Line #3)	$53,208.18

Exhibit U

Mandated Coverages (Chronic Renal Disease, First 12 Months of Treatment)

		Blue Cross	Blue Shield
1.	Estimated new dialysis patients during a 12 month period	37	37
2.	% of population enrolled under Blue Cross and Blue Shield (under age 65)	39.9%	39.9%
3.	Potential Blue Cross and Blue Shield subscribers with renal disease in first 12 months of treatment (Line #1 X Line #2)	15	15
4.	Estimated annual charge for hospital maintenance dialysis	$27,600	$7,500
5.	Total charge to Blue Cross and Blue Shield for dialysis (Line #3 X Line #4)	$414,000	$112,500

Exhibit V

Mandated Coverages (Standard Group Coverage for Employees Age 65 to 69)

		Blue Cross	Blue Shield
1.	Current average rate for coverage of employees under age 65	$39.59	$13.74
2.	% increase in rate for persons over age 65 (provided by consulting actuary)	250%	250%
3.	Estimated average rate for employees over age 65 (Line #1 X Line #2)	$98.98	$34.35
4.	Additional cost per contract month (Line #3 - Line #1)	$59.39	$20.61
5.	Estimated number of employees eligible	1,300	1,300
6.	Estimated contract months for 1983		
7.	Estimated 1983 additional costs (Line #6 X Line #4)	$397,913.00	$138,087.00

#7

STATE OF KANSAS EMPLOYEES
MANDATED HEALTH COVERAGE

	Estimated Cost Per Contract Per Month At 1984 Rate Level		
	Employee	Dependents	Dependents
I. State Mandated Benefits			
A. Chiropractors	$ 0.41	$ 1.80	$ 2.21
B. Dentists	0.31	0.41	0.72
C. Optometrists	0.06	0.20	0.26
D. Podiatrists	0.14	0.26	0.40
E. Newborn Infants (Ill Baby Care)	----	1.37	1.37
F. Psychologists	0.36	0.21	0.57
G. Inpatient NM, Drug Addition, Alcoholism (30 Days or $5,000)	3.75	3.88	7.63
H. Outpatient Psychiatric ($1,000)	2.85	1.92	4.77
I. Total	$ 7.88	$ 10.05	$ 17.93
II. Federal Mandated Benefits			
A. Obstetrical Benefits	$ 3.57	$ ----	$ 3.57
B. Remove OB Waiting Periods	0.81	----	0.81
C. TEFRA Active Employees Age 65-69	1.91	----	1.91
D. Total	$ 6.29	$ ----	$ 6.29
III. Grand Total	$ 14.17	$ 10.05	$ 24.22
IV. Estimated Annual Claims Expense for Mandated Coverages for Non-Medicare Related Contracts Based on 5/84 Contracts			
A. Contract Months Under Age 65	374,016	113,376	------
B. State Mandated Total (Line I-I X Line IV-A)	2,947,246	1,139,429	4,086,675
C. Federal Mandated Total (Line III-D X Line IV-A)	2,352,561	-------	2,352,561
D. Total (Line IV-B + Line IV-C)	5,299,807	1,139,429	6,439,236

LEGISLATORS WARNED ON HIDDEN DANGERS IN MANDATORY BENEFIT LAWS

By LOIS J. LYONS

LITTLE ROCK, Ark.—No matter how innocuous they seem when they are passed, laws mandating certain health care benefits often counteract cost containment efforts—even when they are presented as cost effective. In addition, the increase in mandated benefits is causing an increase in self-funded plans which escape state regulation.

More such laws are being passed in the states every day, but their effect on cost containment and regulation is seldom perceived at the time of passage.

Costs revealed

The hidden costs of legislatively mandated benefits were revealed at the annual meeting of the Conference of Insurance Legislators here, by a state legislative employee and by two members of Blue Cross/Blue Shield Associations.

Each of the speakers warned COIL members not to pass mandated benefits laws without severe scrutiny of their ultimate cost to the overall group.

John B. Welsh Jr. of the office of program research of the Washington State house of representatives, said most of the mandated coverage proposals are being pushed by provider groups to increase their clientele and to assure a steady flow of fees.

"The third-party reimbursement system has been identified as the biggest culprit of the health care cost spiral," he said. "The patient is insulated from the true costs and the provider is given an economic incentive to maximize services regardless of cost benefits.

"This is the equivalent of a patient being offered an a la carte menu with the provider acting as his waiter and encouraging his appetite while the bill is being paid by someone else."

Linda Lanam of Blue Cross/Blue Shield of Washington, D.C., pointed to another reason to hold the reins on mandated benefits. She said that an increasing percentage of the health care marketplace is moving out of insurance and into the self funded marketplace—which means that the impact of mandated benefits lies only on the insured segment.

She warned that this movement into self funded plans also takes away state legislators' and regulators' control for that portion of the benefits marketplace by taking it out of the state insurance regulatory system mechanism completely.

Dr. James M. Young, vice president of Blue Cross/Blue Shield of Massachusetts demonstrated how mandated benefits for psychological and psychiatric care in his state increased dramatically the use of such services and thereby the overall cost of health care in the state.

Cites reasons

Mr. Welsh pointed out some of the reasons for the increase in mandated coverage proposals are the expanding definition of what health care is with health care becoming increasingly technological and new treatments and services appearing yearly; anti-physician sentiment, especially by non-mainstream providers; the expansion of the types of practitioners in the market; changing values and expectations of society; and incomplete coverages.

The proposals, he said, fall into certain categories—those that provide coverage for a very limited number of people; broad base coverages, such as alcoholism treatment, those that attempt to use the insurance delivery system to address a social problem such as mandates to bring more people into the coverage program who would otherwise not be in it; and those that bring in a new provider service, where a health care profession tries to use the insurance mechanism as a marketing stimulus.

Mr. Welsh advised legislators to review mandate proposals to be sure they are truly in the public interest. Analysis, he said, should be as objective as possible, especially in the legislative forum "where too often politics is the art of the possible."

Ms. Lanam explained how state regulation is affected by mandated health benefits laws. She said that ERISA creates a preemption from state regulation of employee benefit welfare plans. State insurance laws affect only that portion of employee benefits that are fully insured, she said, and the self funded portion is growing. She also noted that "no state insurance laws and almost no federal laws apply to the self funded benefits."

She said it may be necessary to consider allowing ERISA to pre-empt state regulation on the issue of benefit design (but not solvency regulation, market conduct or unfair trade practices enforcement) in order to enable the insured community to compete in the self insured marketplace and to bring that portion of the marketplace under appropriate state regulation.

She asked the legislators to look at the issue of mandated benefits not just as individual pieces of legislation, and not just as provider driven issues or public issues, but to decide whether they are the appropriate role for the state legislature and state regulator.

Ms. Lanam also agreed with Mr. Welsh that mandated benefit proposals are increasingly provider driven. "They are affected not by public or consumer interest but all too often by the desire of providers to assure their payment through inclusion in the insurance coverage process," she said.

In addition, she said, many arguments on behalf of these proposals are "encased in the currently popular health care cost containment rhetoric."

State legislators, she advised, must look at the best interest of citizens and not just special interest groups.

According to Dr. Young, Massachusetts was confronted with the detrimental effects of mandatory benefits when the state decided to deinstitutionalize mental patients and at the same time, passed mandated benefits legislation to facilitate it. "Some of the results of this legislation were not foreseen," Dr. Young said.

The mandate for mental health care was passed in December 1973 and applied to all contracts issued in the state after January 1976. The annual dollar amount required was $500 over a 12-month period for each individual insured. He pointed out that in Massachusetts the law requires Blue Cross and Blue Shield to be a non profit insurance company that can insure only for health insurance and no one is denied such insurance. He said some 3.5 million of the state's 6 million residents are covered by the Blues.

Dr. Young showed how the use of psychological services in Massachusetts has grown since the mandate, with the implication that in many cases it is over-used and unnecessary and has raised the cost of health care for the entire group.

He said that since mental illness needs the participation of the patient and the therapist in order for the patient to show progress, "there is a significant advantage if there is a participation in a co-insurance plan, as well.

At the present time," he said, "a co-insurance of about 30 percent would be ideal."

He advised the legislators to not mandate coverages but instead to mandate their offering. "This is a time of free choice. Don't bend to the individual special interest groups. Resist them. Do what is best for the overall group. We will be far better off if you do."

NATIONAL UNDERWRITER (Life & Health Insurance Edition)
11/24/84

BCA TELECOMMUNICATIONS MTT RECEIVED MESSAGE/DATA AND ERROR REPORT

GENERAL ADM FROM BCA CYCLE # CARD #

#9

(WARNS LAWMAKERS ON MANDATED BENEFITS)

(MINNEAPOLIS) -- GOVERNMENT MANDATED BENEFITS ACCOUNT FOR ONE OF THE BIGGEST PROBLEMS IN LIMITING HEALTH CARE COSTS, ACCORDING TO THE HEAD OF A MINNESOTA COALITION STRIVING TO KEEP HEALTH COSTS DOWN, THE SEPTEMBER 1 NATIONAL UNDERWRITER REPORTED.

SPEAKING AT A SEMINAR SPONSORED BY THE CONFERENCE OF INSURANCE LEGISLATORS, HARRY L. SUTTON, WHO HEADS THE COALITION ON HEALTH CARE COSTS, SAID THAT ''IF ALL LEGISLATORS WOULD STOP TRYING TO LEGISLATE MANDATED BENEFITS, IT WOULD CUT COSTS ENORMOUSLY.''

SUTTON SAID LEGISLATORS SHOULD BE CAUTIOUS ABOUT THE BENEFITS THEY MANDATE, ADDING THAT THEY SHOULD NOT ALLOW ''INDIVIDUAL LOBBYING GROUPS (TO) CONVINCE YOU THAT THE LEGISLATION YOU PASS WILL CUT COSTS.''

ACKNOWLEDGING THAT SOME OF THE PROBLEMS ADDRESSED BY MANDATED BENEFITS ARE SEVERE AND REAL, SUTTON SAID THAT EXPANSION OF COVERAGE ''AD NAUSEUM'' ALSO WILL EXPAND UTILIZATION, INCREASE THE NUMBER OF PROVIDERS AND EVENTUALY INCREASE COSTS, THE ARTICLE REPORTED.

THE UNDERWRITER SAID SUTTON NOTED THAT THE MORE BENEFITS ARE MANDATED, THE MORE EMPLOYERS SEEK TO SELF-INSURE BECAUSE STATE LAWS THAT AFFECT INSURANCE COMPANIES DO NOT AFFECT THOSE SELF-INSURING. MANY SMALLER COMPANIES ARE NOW GOING TO SELF-INSURED ROUTE, THE COALITION LEADER SAID, AND SOME LARGER EMPLOYERS AT THE SAME TIME ARE BREAKING THE TRADITION THAT THE BENEFITS THEY OFFER EMPLOYEES WILL AGREE WITH STATE REQUIREMENTS.

SUTTON SAID THIS COULD HAVE MARKETPLACE IMPLICATIONS, ADDING THAT THE ''HEAVY BURDENS'' PLACED ON CARRIERS ''WILL FORCE PREMIUM RATES FOR SMALL COMPANIES WAY UP, WHILE THE LARGE EMPLOYERS ARE LOOKING FOR WAYS TO CUT BACK,'' THE UNDERWRITER REPORTED.

#11

TOTAL NUMBER OF STATES WITH MANDATED COVERAGES

Category	Coverage	Number of States
PRACTITIONERS	NURSES	3
	Nurse Midwives	17
	Nurse Practitioners	8
	Nurse Anesthetists	2
	THERAPISTS	
	Physical	2
	Occupational	2
	Speech/hearing	3
	COUNSELORS	
	Psychologists	34
	Psychiatric Nurses	6
	Social Worker	10
	DENTISTS	23
	ORAL SURGEONS	2
	OPTOMETRISTS	22
	PODIATRISTS	16
	CHIROPRACTORS	26
	OSTEOPATHS	8
	OTHER	5
BENEFITS	ALCOHOLISM	38
	DRUG ABUSE	15
	MENTAL HEALTH	26
	BREAST RECONSTRUCTION	8
	MATERNITY	15
	PRESCRIPTION DRUGS	2
	CLEFT PALATE	2
	DIABETIC EDUCATION	3
	DIABETIC OUTPATIENT	2
	SECOND OPINION	3
	HOME HEALTH	15
	HOSPICE	5
	AMBULATORY SURGERY	9
	ANTI-ABORTION	6
	PUBLIC INSTITUTIONS	4
	OTHER HEALTH CENTERS	9
DEPENDENT COVERAGE	DEPENDENT STUDENTS	4
	ADOPTED CHILDREN	2
	NEWBORNS	45
	MENTALLY/PHYSICALLY HANDICAPPED	32
	NON-CUSTODIAL CHILDREN	2
CONVERSION/ CONTINUATION	CONVERSION PRIVILEGE	28
	SURVIVORS	14
	DIVORCED SPOUSE	23
	DISABLED EMPLOYEE	9
	CATASTROPHIC COVERAGE	3
	POOL	7
	MISCELLANEOUS:	32

1974 - 48 Mandates

1984 - 562 Mandates

EXHIBIT ~~11~~ 12

Exempt areas create complications.

For the first time a competitive atmosphere is developing in the health care field.

Employers want more flexibility, not less.

- MOST CARRIERS OFFER MULTIPLE CONTRACTS
- BUYERS WANT FLEXIBILITY
- MANDATING BENEFITS HAS NEVER REDUCED COSTS
- SOME CONTRACTS ARE ALWAYS EXEMPT
    - LABOR NEGOTIATED CONTRACTS
    - NATIONAL ACCOUNTS
    - HMO'S
    - FEP
    - SELF-INSURED
    - PREFERRED PROVIDER ORGANIZATIONS (PPO'S)

EXHIBIT ~~12~~ 13

Why self-insure?

Self-insured in Kansas.

WHY SELF-INSURE?

1. ELIMINATE PREMIUM TAX

2. INCREASE CASH FLOW

3. AVOID MANDATED BENEFITS AND/OR REGULATION

SELF INSURED ACCOUNTS

KANSAS PLAN AREA

Enrolled Accounts
(As of 12-31-83)

COMPANIES	CONTRACTS	SUBSCRIBERS
14	13,154	30,976

Unenrolled Accounts

COMPANIES	INSTALLATIONS	EMPLOYEES	SUBSCRIBERS
169	445	74,511	175,466

	COMPANIES	CONTRACTS/EMPLOYEES	SUBSCRIBERS
TOTALS	183	87,665	206,442

Excluding under age 18 individuals, institutionalized, etc., the 206,442 subscribers represents approximately 15% of eligible Kansans (includes Johnson and Wyandotte counties).

#14

MT030R01 REL 2 VER C3 BCA TELECOMMUNICATIONS MTT RECEIVED MESSAGE/DATA AND ERROR REPORT
GENERAL ADM FROM BCA
+=TPK-0150+=BCAN009 00904.85035 1649 85035 1652<
APMX

TO: ALL BLUE CROSS AND BLUE SHIELD PLANS

ATTENTION: PLAN PUBLIC RELATIONS DIRECTORS

SUBJECT: THE BLUE CROSS AND BLUE SHIELD DIGEST

DATE: FEBRUARY 5, 1985

- 0 -

(SURVEYS FIND HEALTH BENEFIT SELF-FUNDING ON RISE)

(CHICAGO) -- THE NUMBER OF EMPLOYERS SELF-FUNDING THEIR GROUP HEALTH CARE PLANS ''IS EXPLODING'' AND, ''FOR THE FIRST TIME, EMPLOYERS THAT USE SOME VARIATION OF SELF-INSURANCE NOW OUTNUMBER EMPLOYERS THAT FULLY INSURE THEIR HEALTH BENEFITS, ACCORDING TO RECENT SURVEYS,'' BUSINESS INSURANCE REPORTED IN ITS JANUARY 28 ISSUE.

IN A SERIES OF ARTICLES, THE PUBLICATION REPORTED THAT EXPERTS SAY EMPLOYERS ARE TURNING TO SELF-INSURANCE ''FOR ONE MAIN REASON: TO CUT THEIR BENEFIT COSTS.'' IN ADDITION, SELF-INSURANCE CAN AVOID STATE PREMIUM TAXES AND ALSO EARN INTEREST ON RESERVES SET ASIDE TO PAY CLAIMS.

''EMPLOYERS ARE LOOKING TO SQUEEZE EVERY (HEALTH CARE) DOLLAR,'' THE MAIN ARTICLE QUOTED RICHARD SEIDEN, A SENIOR VICE PRESIDENT AT FRANK B. HALL CONSULTING CO. IN NEW YORK.

ACCORDING TO BUSINESS INSURANCE, A 1984 SURVEY BY THE WYATT CO. OF 268 COMPANIES FOUND 57 PERCENT WERE SELF-FUNDING THEIR MEDICAL PLANS IN SOME WAY, COMPARED WITH 19 PERCENT IN 1980.

THE ACCOUNTING FIRM OF COOPERS & LYBRAND ALSO CONDUCTED A SURVEY OF 302 COMPANIES LAST YEAR, AND FOUND THAT 60.9 PERCENT WERE EITHER SELF-FUNDING OR USING MINIMUM PREMIUM PLANS COMBINING INSURANCE AND SELF-FUNDING, THE ARTICLE SAID.

BCA TELECOMMUNICATIONS MTT RECEIVED MESSAGE/DATA AND ERROR REPORT
GENERAL ADM FROM BCA

DAVID LEMIRE, A REGIONAL VICE PRESIDENT FOR CONNECTICUT GENERAL LIFE, A CIGNA CORP. UNIT, TOLD THE PUBLICATION THAT IN 1980, THE ''VAST MAJORITY OF OUR CUSTOMERS WERE FULLY INSURED.'' BUT NOW, HE ADDED, HEALTH CARE BUSINESS IS ''SPLIT EVENLY'' BETWEEN FULLY INSURED EMPLOYERS AND EMPLOYERS THAT PURCHASE MINIMUM PREMIUM PLANS OR MAKE USE OF THE INSURER IN AN ADMINISTRATIVE-SERVICES-ONLY CAPACITY.

AT METROPOLITAN LIFE, THE ARTICLE SAID, SOME 80 PERCENT OF CLIENTS ARE SELF-FUNDING THEIR HEALTH CARE PLANS TO SOME EXTENT, UP FROM 50 PERCENT A DECADE AGO, ACCORDING TO EDWARD SHULTZ, A VICE PRESIDENT IN NEW YORK. SHULTZ SAID HE WOULD BE ''HARD-PRESSED'' TO FIND A LARGE CLIENT THAT WASN'T AT LEAST PARTIALLY SELF-INSURED.

IN ANOTHER ARTICLE, A COOPERS & LYBRAND SURVEY FOUND THAT IN THE NATURAL RESOURCES INDUSTRY, ONLY 15.4 PERCENT OF EMPLOYERS INSURED THEIR HEALTH CARE PLANS. OF 300 EMPLOYERS SURVEYED, THE ARTICLE SAID, ALTERNATIVE FUNDING TECHNIQUES WERE POPULAR IN THE EMPLOYER CATEGORY THAT INCLUDED FOOD PRODUCTS, TOBACCO, TEXTILES, APPAREL, LUMBER AND WOOD, FURNITURE, PAPER, PRINTING AND PUBLISHING MANUFACTURERS.

FULLY INSURED PLANS ARE STILL POPULAR IN CERTAIN INDUSTRIES, THE ARTICLE REPORTED, NOTING THAT 52.4 PERCENT OF THE SURVEYED COMPANIES IN THE MEDICAL AND HEALTH INDUSTRIES WER FULLY INSURED, COMPARED TO 28.6 PERCENT WHICH WERE SELF-FUNDED AND 19 PERCENT WHICH USED MINIMUM PREMIUM PLANS.

ANOTHER ARTICLE SAID THAT WHILE ADVANCES IN MEDICAL TECHNOLOGY ''ARE SAVING LIVES THAT PREVIOUSLY WOULD HAVE BEEN LOST...THEY'RE ALSO BALLOONING THE COST OF STOP-LOSS INSURANCE FOR EMPLOYERS THAT SELF-FUND THEIR MEDICAL BENEFITS.'' IT ADDED THAT UNDERWRITERS SAY RATES FOR SPECIFIC STOP-LOSS COVERAGE ''ARE RISING ANYWHERE FROM 20 PERCENT TO 100 PERCENT IF THE EMPLOYER'S RETENTION REMAINS THE SAME.''

#15

DEPARTMENT OF DEFENSE MEDICAL FACILITIES

BILLING OF PRIVATE INSURANCE

This action would make all insurers primary for services received by non-active duty personnel in military facilities.

With this change, the Federal Government is shifting to the private sector - primary employers - a new set of financial obligations without the authority or safeguards needed to contain the escalation in private sector health care costs that will surely follow.

Almost all insurers exclude services provided in government owned facilities such as military hospitals. Because services rendered by these facilities are not covered, their cost is not reflected in the premium. If employers have to pay for care provided in military facilities, their premiums would rise accordingly.

Such a policy change would have a negative impact on:

- Employers efforts to curb costs. (Such as through employer coalitions, preferred provider arrangements, and HMO's)
- Community health care cost containment efforts.

The military facility would have no obligation to pursue cost containment activities, it's mix of patients may be different, their methods of computing costs may differ, and they would not have to enter into contracts.

TAX "CAPS" ON HEALTH INSURANCE

It is estimated that such a tax "cap" would have generated $2,100,000,000 in 1984 and around $8,600,000,000 by 1988. Thus it is perceived by some as an attractive change in tax policy.

The most frequently mentioned concept would place a "cap" on monthly premiums of $175 a month for family coverage and $75 a month for one person coverage. (A more moderate proposal of $250 on family monthly premiums has also been suggested.) It would apply to all employers, regardless of size, and would include self-insurance plans and HMO's. Some feel it would reduce the use of medical services, thus reducing the nation's health care bill.

Response: Following is a quick summary response to the imposition of a tax "cap".

- It would create serious administrative problems for many employers; even those employers who purchase traditional third party insurance coverage may have a problem in determining each employees taxable liability.

  Most certainly those employers who self-insure would find it a bookkeeping "nightmare" in assessing tax liability for each employee as the total premium to be charged to each employee is not known until three or four months after the end of their contract year.

- It would create a tendency towards a two-third system of health insurance, that is, the very healthy seeking coverage that would come within the "caps" (therefore no tax liability) and the heavier users demanding more comprehensive supplemental coverage above the "cap limitation" to "fill in the gaps". Since there would be no credible "spread of risk" among the latter group the premium rate would become increasingly unaffordable.

  Therefore, the least healthy may be placed in a position of finding it more difficult to prepay needed health care and may ultimately come full circle and back on the public "coffers".

- Employers (and employees) may respond to the tax cap by dropping those benefits which are most cost effective, such as, outpatient and preventive services.

- The tax would be regressive and place a greater burden on low-income individuals.

- It would have an adverse effect on older, disabled, and chronically ill workers because employers would be discouraged from hiring such persons because their premiums would be higher.

TAX "CAPS" ON HEALTH INSURANCE
(continued)

- It could impede the development of HMO's. These prepaid systems offer more comprehensive coverage at a higher than average premium.
- A national uniform "CAP" would be inequitable. Employees in areas of high health care costs would be penalized unfairly.
- Tax caps may not generate the expected revenue. Employers may try to shift excess health fringe benefit contributions to other nontaxed fringes.
- It is another tax and would create an additional $228 annual tax (1984) on the average worker.

YOUR PRIMARY IMPACT WOULD BE ON

EMPLOYEE GROUPS

	# of Groups	# of Contracts	# of Subscribers
Less than 10 Contracts	12,606	29,730	71,602
10 - 24	1,122	16,950	41,373
25 - 99	815	38,043	89,952
TOTALS	14,543	84,723	202,927

AND, POSSIBLY, IN ADDITION . . . . .

Farm	9,900	25,310
Non-Group (Direct & Conversions)	5,400	8,160
Plan 65 (Now have Psychiatric Coverage Through Medicare)	153,435	153,435
	168,735	186,905

(As of 7-1-84)

#18

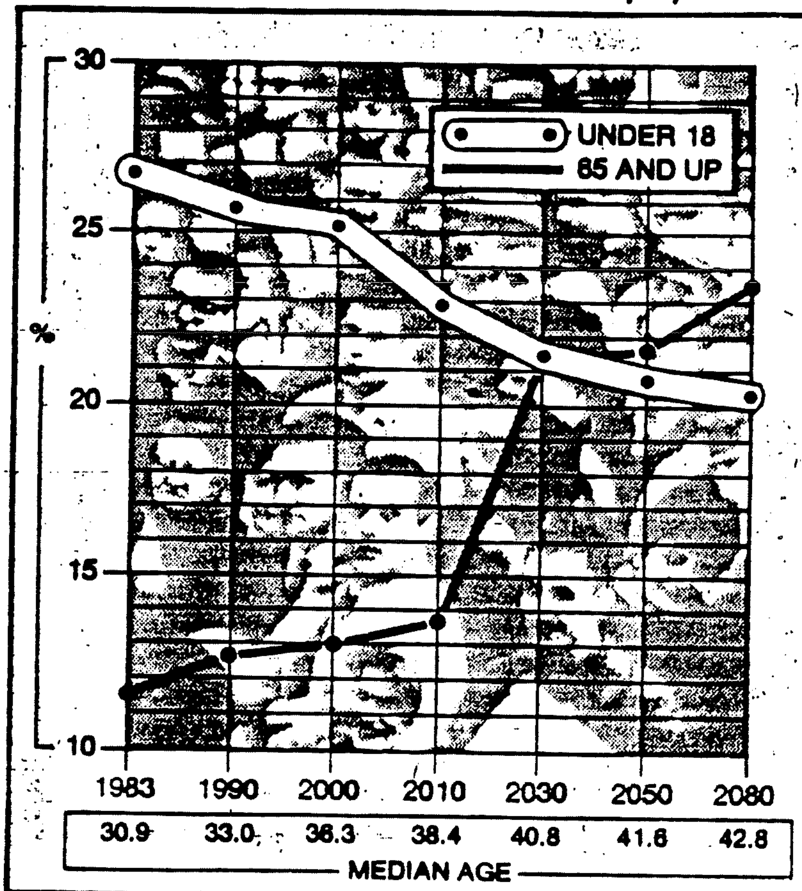
DEMOGRAPHIC REVOLUTION

AMERICANS NOW OVER 65	BY 2035
25,000,000	55,000,000
11% Of Population	20% Of Population

By 2040 -- The 75+ Will Be In The Majority -- More Of Them Than There Are 65+ Today

THE AGING OF AMERICA

Census Bureau foresees an 'older' population



(Source: U.S. Census Bureau)

NEA GRAPHIC

Population concentrated

In 1980 about half (45 percent) of persons 65 and older lived in seven states. California and New York had more than 2 million each, and Florida, Illinois, Ohio, Pennsylvania and Texas each had more than 1 million.

Persons 65 and older constituted 13 percent or more of the population in eight states: Florida (17 percent), Arkansas (14 percent), Rhode Island, Iowa, South Dakota, Missouri, Nebraska and Kansas (13 percent each).

Persons 65 and older were slightly less likely to live in metropolitan areas than younger persons (64 percent of the elderly, 68 percent of other ages).

No rate increase under Plan 65

Capital-Journal 10/18/84

For the first time in 16 years, Blue Cross and Blue Shield of Kansas isn't asking the state for a rate increase for subscribers of Plan 65, which supplements Medicare coverage for senior citizens.

The announcement today from Fletcher Bell, state insurance commissioners, comes two months after Blue Cross said it would buck another 16-year trend and not seek increased rates for other coverage plans.

"There are currently 152,400 Kansans covered under Plan 65, and this is the first time since 1968 that Kansas Blue Cross and Blue Shield has not filed for an increase in their rates," Bell said. "I know our senior citizens will be pleased at this turn of events."

Blue Cross and Blue Shield operates in every county except Wyandotte and Johnson and is the largest provider of health insurance in Kansas.

Blue Cross officials credited their decision with a decline in hospital admissions and participation of physicians and hospitals in programs designed to hold down costs for medical care.

(NEW YORK) -- AMERICANS 85 AND OVER MAKE UP THE FASTEST-GROWING SEGMENT OF THE U.S. POPULATION, AND THE TREND COULD PLACE A STRAIN ON THE NATION'S HEALTH CARE SYSTEM, ACCORDING TO A NUMBER OF NEWS SOURCES.

THE NUMBER OF PERSONS AGED 85 AND OVER NOW TOTALS ABOUT TWO MILLION MOSTLY —WOMEN, AND THIS SEGMENT OF THE AGED IS EXPECTED TO TOP 5.4 MILLION BY THE YEAR 2000, POSSIBLY RISING TO ONE PERSON IN 20 BY THE YEAR 2050, POPULATION SPECIALISTS ESTIMATE.

BARBARA TORREY, AN ECONOMIST WITH THE U.S. CENSUS BUREAU, PREDICTS THAT BY THE TURN OF THE CENTURY CARE FOR THE NATION'S VERY OLD (THOSE IN THEIR 80S AND 90S) WILL COST THE UNITED STATES AT LEAST $85 BILLION, BASED ON 1984 DOLLARS, AN INCREASE OF 67 PERCENT IN THE NEXT 15 YEARS. ACCORDING TO TORREY, THE NATION NOW SPENDS $51.2 BILLION ON FEDERAL BENEFITS (MEDICARE AND SOCIAL SECURITY) FOR SIX MILLION AMERICANS OVER 80, WHOSE NUMBERS WILL INCREASE TO 10.1 MILLION BY 2000, THE ASSOCIATED PRESS REPORTED.

TORREY, WHO PRESENTED HER STUDY AT THE ANNUAL MEETING OF THE AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, NOTED THAT FEW STUDIES HAVE BEEN CONDUCTED ON THESE VERY OLD PEOPLE. ''THE ARE STATISTICAL GHOSTS,'' SHE SAID, WHO LEAVE ''ONLY A TRAIL OF COSTS AND A FEW CLUES TO THEIR ECONOMIC RESOURCES.''

SHE ALSO ADDED THAY BY THE YEAR 2000, MORE BENEFITS WILL BE PROVIDED TO OCTOGENERIANS THAN ANY OTHER SUBGROUP OF THE AGED OR THE GENERAL POPULATION, INCLUDING VETERANS AND THE POOR.

AT THE SCIENCE GROUP'S MEETING, DR. EDWARD SCHNEIDER, OF THE NATIONAL INSTITUTE ON AGING, SAID THE 85 AND OVER AGE GROUP NOW CONSTITUTES LESS THAN ONE PERCENT OF THE POPULATION BUT FILLS MORE THAN 20 PERCENT OF THE BEDS IN NURSING HOMES. IT'S ALSO AN AGE GROUP IN WHICH CHRONIC DISEASES AND DISORDERS OF AGING TAKE THEIR TOLL. ONE OF THE MOST TROUBLING HEALTH PROBLEMS OF THIS AGE GROUP IS LOSS IN MENTAL FUNCTION.

THE EXPLOSION IN LIFE EXPECTANCY FOR THOSE IN THEIR 80S OR MORE WAS ATTRIBUTED BY POPULATION SPECIALISTS TO THE MAJOR REDUCTIONS IN THE TOLL FROM INFECTIOUS DISEASES AND A DECLINE IN DEATHS DUE TO DISEASES OF THE HEART AND CIRCULATORY SYSTEM.

IRA ROSENWAIKE, A POPULATION SPECIALIST FROM THE UNIVERSITY OR PENNSYLVANIA, SAID WOMEN FAR OUTNUMBER MEN IN THE 85-PLUS GROUP. IN FACT, HE NOTED, THERE ARE NOW ONLY 44 MEN FOR EVERY 100 WOMEN OVER AGE 85, COMPARED TO EIGHT FOR EVERY 10 AT THE AGE LEVEL OF 65 TO 69.

2-14-85

2167

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

Room 545-N — Statehouse

Phone 296-3181

Attachment II

RE: HEALTH INSURANCE OPTIONS FOR UNINSURABLES

Some individuals with chronic illnesses or conditions needing frequent medical attention often have trouble obtaining health insurance coverage. In fact, such persons, unless eligible for insurance under a group policy at work or unless poor enough or old enough to be covered under Medicaid or Medicare respectively, may find health insurance inaccessible.

Concern about the problem of "uninsurables" is reflected in discussion, by a number of state legislatures, of bills creating a pooled-risk mechanism to provide an insurance option to persons unable to purchase coverage under normal underwriting standards. Seven states have enacted legislation addressing this issue. Also, the National Association of Insurance Commissioners has adopted a "Model Health Insurance Pooling Mechanism Act." Although no single "model" can provide the most effective response to questions of insurance availability in every state, the NAIC model act and the existing state statutes addressing the issue may be useful discussion pieces providing a point of departure for Kansas legislators.

Attached is a table describing some of the significant provisions of the NAIC model act and the state legislation passed to assure that reasonable insurance coverage is available to uninsurables. The general structure of each model is based on establishment of a state "pool" of which all health care financing mechanisms (insurers, nonprofit service plan corporations, health maintenance organizations (HMOs), and self-insurers) would be members. Pool coverage would consist of broad comprehensive benefits with, in some cases, a choice of a "high" or a "low" deductible. A pool made up of uninsurable risks would require premium rates to be higher than those of standard risk policies, and each statute sets up a standard regulating the relationship between these rates. Pool losses beyond the maximum rate would be assessed to each pool member in proportion to the volume of business done in the state. A few states provide that such assessments may be offset against the income tax or premiums tax liability of the health care financing entity.

Attachment II
2-14-85 HB 2167

SELECTED PROVISIONS OF STATUTES/MODELS INTENDED TO PROVIDE REASONABLE HEALTH INSURANCE COVERAGE TO "UNINSURABLES"

Statute	Eligibility Requirements[1]	Premium Rates	Coinsurance Provisions[3]	Annual Deductible[4]	Maximum Lifetime Benefit	Pre-Existing Condition Limitation[5]
Connecticut Conn. Gen. Stat. Ann. §38-371 (West 1984)	Must be ineligible for Medicare	Between 125%-150% of average group rate charged for given classification under a policy covering ten lives	50%-50% to 20%-80%, depending on nature of services	$200/person; $500/person; or $750/person; depending on program	Not less than $1,000,000/person	Optional exclusion for up to 12 months
Florida Fla. Stat. Ann. §627.648 (West 1984)	Rejection by two insurers	Initially 150% of standard risk rates; maximum of 200% of standard risk rate[2]	20%-80%	$1,000/person; $1,500/person; or $2,000/person; depending on program	Up to $500,000/ person	Same as for Connecticut
Indiana Ind. Code Ann. §27-8-10-1 (Burns 1984)	Same as for Florida	Maximum 150% of average rates of five carriers with largest premium volume	20%-80%	$200/person		Optional exclusion for six months
Minnesota Minn. Stat. Ann. §62E.01 (West 1984)	Rejection by at least two insurers within past six months or restrictive riders or discriminatory requirements in policy	Maximum 125% of average rates of five carriers with largest premium volume	20%-80%	Minimum: $500/person; Maximum: $1,000/person	$250,000/person	Exclusion for six months
North Dakota N.D. Cent. Code §26.1-08-01 (1983)	Same as for Minnesota	Maximum 135% of average rates of five insurers with largest enrollment	Same as for Minnesota	$150/person; $500/person; or $1,000/person; depending on program	Not less than $250,000/person	Same as for Minnesota

Statute	Eligibility Requirements (1	Premium Rates	Coinsurance Provisions (3	Annual Deductible (4	Maximum Lifetime Benefit	Pre-Existing Condition Limitation (5
Rhode Island						
R.I. Gen. Laws §42-62-4 (1983)	Must be ineligible for Medicare	—	20%-80%	$100	$10,000 - $15,000/person	Exclusion for 12 months
Wisconsin						
Wis. Stat. Ann. §619.10 (West 1984)	Must be under age 65. Notice of cancellation or rejection by at least two insurers or restrictive riders or discriminatory requirements in policy	Maximum 150% of comparable standard policy	20%-80%	$1,000/person		Same as for Minnesota
NAIC Model Act	Persons unable to purchase health insurance coverage at a reasonable price in the marketplace	Initially 150% of standard risk rates; maximum of 200% of standard risk rate	20%-80%	$500/person or $1,500/person, depending on program	$1,000,000/ person	Exclusion for 12 months

1) This table covers only the most restrictive aspects of eligibility. Particular statutes often have other restrictions, such as a requirement that an applicant not be covered by any other health insurance plan. It should be noted that all plans include state residency as a requirement.

2) Limitations to be repealed October 1, 1987.

3) All plans provide for 100 percent coverage at a point when annual per person out-of-pocket expenses reach a stated threshold, ranging from $1,000 to $3,000.

4) Some plans provide for yearly adjustment based on the medical component of the Consumer Price Index.

5) Most plans specify that the pre-existing condition must have been diagnosed or treated within a certain time preceding application for the pool policy.

A85-9/melinda