Approved 2-26-85
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Roy M. Ehrlich at
Chairperson

10:00 a.m.~~p.m.~~ on February 18, 1985 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Conferees appearing before the committee:
Don Strohle, Board of Healing Arts
Abby Horak, RN
Janice Noyes, RN
Dr. Lois Scibetta, Executive Director, Kansas State Board of Nursing
Harold Riehm, Kansas Association of Osteopathic Medicine
Secretary Barbara Sabol, Department of Health & Environment
Jack Roberts, Blue Cross, Blue Shield
Richard Huncker, Kansas Insurance Department
Others Attending: See Attached List

SB-125 - midwifery - licensure of midwives

Don Strohle testified and presented written testimony concerning SB-125. Mr. Strohle testified that the Board of Healing Arts has consistently construed the Healing Arts Act K.S.A. 65-2801 et seq. to prohibit the practice of lay midwifery. Attachment I

Abby Horak, RN testified and presented written testimony opposing SB-125. The primary objection to SB-125 was that the results of the bill could be misleading due to the fact that the public would assume the lay midwife was adequately and appropriately prepared to safely provide prenatal care and attend home deliveries. Consumers would be led to believe that the state designated these persons as safe. Attachment II

Janice Noyes, RN testified and submitted written testimony opposing SB-125. Ms. Noyes is certified by the Nurses' Association of American College of Obstetricians and Gynecologists as a nurse practitioner and licensed as such by the Kansas State Board of Nursing in the specialty area of obstetrics and gynecology. Ms. Noyes testified that there is nothing in this bill which addresses standards - standards of practice, standards of educational preparation, standards of testing and no mention of rules and regulations other than they will be established by the council if the skill of the attendant is integral to the successful outcome of birth. This fact, coupled with the fact that lay individuals propose to designate themselves as legitimate caregivers is unsafe. Attachment III

Dr. Lois Scibetta, Executive Director of Kansas State Board of Nursing, testified and presented written testimony setting out several sections of the bill which are not specific and give the board serious concern, such as if a succeeding secretary were not a nurse and aware of inherent dangers. The Board urged the committee to vote against this bill in order to protect the public health, safety and welfare of the citizens of Kansas. Attachment IV

Harold Riehm, Kansas Association of Osteopathic Medicine presented written testimony to the committee opposing SB-125. Mr. Riehm stated that Kansas has established a fair and thorough proceedure within the Statewide Health Coordinating Council, by which providers of health care services may seek license credentialing review. It was also stated that the organization was in agreement with the findings of the Board of Healing Arts that the practice of midwifery does involve the practice of medicine and that in the case of midwifes, these obstetrical services should be conducted only under the supervision of a licensed physician. Attachment V

Secretary Barbara Sabol, Secretary of the Department of Health and Environment testified and will submit written testimony to the committee. Secretary Sabol testified that the department perceived the basic issue of SB-125 seems to be whether or not midwifery is a health occupation. It is the conception of Secretary Sabol that midwifery is, as defined in SB-125, indeed a health occupation. She further stated that the department's position is that midwives should go through the established credentialing route. This process can be initiated on the basis of 100 signatures. The purpose of the credentialing process was to have these kinds of issues reviewed through a mechanism to minimize the emotionality and get down to specifics the issue is raising. The process takes 5-6 months to complete and at the end of this time the secretary makes a recommendation to the legislature and ultimately it will require legislative action if the SHEC and the Secretary would recommend that this become a licensed or registered group. Secretary Sabol directed the proponents to the requirements under K.S.N. 65-501 and that they should use the credentialing mechanism. It was also pointed out that there is a manual for applicants to help them get through the process and technical assistance by the department to help them.

SB-121 - mandatory health insurance risk sharing plan

Jack Roberts, Blue Cross and Blue Shield gave testimony and presented written testimony on SB-121. Mr. Roberts stated that this legislation will most likely result in an increase to all those now paying for health insurance coverage and that "affordability" will be a problem. Mr. Roberts testified that the organization would expect losses to exceed income, therefore requiring that it be subsidized by those who are paying for insurance and that mandates always increase costs. Attachment VI

Richard Huncker, Kansas Insurance Department testified that Commissioner Bell supports a residual market mechanism which would have the result of assuring the availability of reasonably comprehensive health insurance coverage to Kansas residents. The commissioner feels that the legislative proposal set forth in the 1984 HB-2167 meets this need. Although HB-2167 addresses only the availability of health insurance coverage it is a proposal that provides a great deal of flexibility from an administration standpoint. Nevertheless Commissioner Bell feels that an availability for Kansas residents for health insurance is an absolute necessity and he supports SB-121.

Mr. Huncker's testimony was to be continued tomorrow, Tuesday, February 19, 1985.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2/18/85

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
JACK ROBERTS	BC-BS
ROD LAKE	KASB
Dr Lois Rich Scibetta	KSBN
John Crane	KS Assoc Homes for Aging
Marilyn Bradt	Assn for Improvement of Homes
KEITH R LARNDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Connie Stewart	KS. AFL-CIO
Elizabeth W. Carlson	Bd of Healing Arts
Arlen Whitfield	SRS

SB-125 - Don Strohla Bd. Healing Arts - 2-14-85

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF
RICHARD A. UHLIG, SECRETARY
ELIZABETH W. CARLSON, EXECUTIVE SECRETARY
DONALD G. STROLE, GENERAL COUNSEL
503 KANSAS AVENUE, SUITE 500
TOPEKA, KANSAS 66603-3449
PHONE (913) 296-7413

TESTIMONY OF STATE BOARD OF HEALING ARTS ON SB 125

Chairman and Members of the Committee:

In order to put this bill in proper perspective, I thought I would give some background as to how the Board construes the law in regard to midwifery and how the Board has dealt with complaints about midwives.

The Board has consistently construed the Healing Arts Act, K.S.A. 65-2801 et seq to prohibit the practice of lay midwifery. I have attached a 1978 Attorney General's Opinion which analyzes the law in detail. Essentially, the opinion stated that midwifery is obstetrics and obstetrics has always been considered part of the practice of medicine. The opinion concluded by saying that only persons licensed by the Board can practice medicine and therefore, only they can practice obstetrics.

There are two exceptions to this conclusion -- Nurse midwives who are licensed and certified by the Board of Nursing and the general exception to the Healing Arts Act found in K.S.A. 65-2872(g), where a person who practices under the supervision of a physician is exempted from the Act.

The Board, as some of you may know, recently sought an injunction against a lay midwife practicing in Ulysses. The baby died in that case, which no doubt is why it was brought to our attention. The lay midwife had taken some midwifery courses in Texas and in the particular case was working without supervision by a physician. Thus, the Board believed she was practicing medicine without a license

Attachment I
2/18/85

and sought an injunction to prohibit her from practicing in the future. Eventually, the case was resolved by the defendant agreeing to work only with a backup physician who will be available in case of complication and for examination, and to review the prenatal records of the patient. I have attached a copy of the Court's Order in that case.

The Board's position on midwifery is that it is practicing obstetrics and thus, only persons licensed by the Board or Nurse Midwives should be practicing it. The Board feels that the complications which can occur at any point in a pregnancy require the knowledge and training of a physician or at least a Nurse Midwife. SB 125 does not provide for or require such training or knowledge and thus, the Board opposes the passage of it. The Secretary of the Board will testify in detail later about the numerous complications which can occur in a pregnancy which the Board believes necessitates the involvement of a physician.

Thank you for your time and attention.

prohibited in the practice of chiropractic under act. Acupuncture Society of Kansas v. Kansas Bd. of Healing Arts, 226 K. 639, 643, 602 P.2d 1311.

65-2802. Definitions. For the purpose of this act the following definitions shall apply:

(a) The healing arts include any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, or injury, and includes specifically but not by way of limitation the practice of medicine and surgery; the practice of osteopathic medicine and surgery; and the practice of chiropractic.

(b) "Board" shall mean the state board of healing arts.

(c) "License" shall mean a license to practice the healing arts granted under this act.

(d) "Licensed" or "licensee" shall mean a person licensed under this act to practice medicine and surgery, osteopathic medicine and surgery or chiropractic.

(e) Wherever the masculine gender is used it shall be construed to include the feminine, and the singular number shall include the plural when consistent with the intent of this act.

History: L. 1957, ch. 343, § 2; L. 1976, ch. 273, § 1; Feb. 13.

Revisor's Note:
Referred to in 60-427.

Cross References to Related Sections:
Other definitions, see 65-2837; 65-2868 to 65-2872; 65-2874 to 65-2876.

Law Review and Bar Journal References:
Mentioned in "The Physician-Patient Privilege Under the New Code," Steven P. Flood, 33 J.B.A.K. 100, 102 (1964).
Kansas law discussed in "The Psychotherapists' Privilege," Craig Kennedy, 12 W.L.J. 297, 307 (1973).

CASE ANNOTATIONS

1. Cited in discussing but not determining whether a chiropractor is a physician or surgeon within meaning of 44-510. Grantham v. Coleman Co., 190 K. 468, 470, 375 P.2d 629. Paragraph deleted from opinion in opinion denying rehearing. 190 K. 634, 376 P.2d 908.
2. Cited in upholding revocation of license by board pursuant to 65-2848. Kansas State Board of Healing Arts v. Foote, 200 K. 447, 452, 436 P.2d 828.

65-2803. License prerequisite to practice of the healing arts. No person shall engage in the practice of any branch of the healing arts, as hereinafter defined, unless he shall have obtained from the board a license for that purpose.

History: L. 1957, ch. 343, § 3; July 1.

Research and Practice Aids:
Hatcher's Digest, Physicians and Surgeons § 2.

CASE ANNOTATIONS

1. Cited in upholding revocation of license by board pursuant to 65-2848. Kansas State Board of Healing Arts v. Foote, 200 K. 447, 452, 436 P.2d 828.

65-2804. Permanent licenses; qualifications of applicants. No person shall receive a permanent license under this act until such person shall have furnished satisfactory evidence to the board that such person has attained legal age and is of good moral character. In determining moral character under this section, the board shall take into consideration any felony conviction of such person, but such a conviction shall not automatically operate as a bar to licensure.

History: L. 1957, ch. 343, § 4; L. 1969, ch. 299, § 1; L. 1972, ch. 231, § 7; L. 1976, ch. 273, § 2; Feb. 13.

Research and Practice Aids:
Hatcher's Digest, Physicians and Surgeons §§ 2, 3.

65-2805. License refused, when. The board may refuse to grant a license to any person, otherwise qualified, upon any of the grounds for which a license may be revoked under the provisions hereinafter contained.

History: L. 1957, ch. 343, § 5; July 1.

Research and Practice Aids:
Hatcher's Digest, Physicians and Surgeons §§ 2, 3.

CASE ANNOTATIONS

1. Cited in upholding revocation of license by board pursuant to 65-2848. Kansas State Board of Healing Arts v. Foote, 200 K. 447, 452, 436 P.2d 828.

65-2806. Form and type of license. Every license to practice a branch of the healing arts shall be in the form of a certificate and of a type prescribed by the board.

History: L. 1957, ch. 343, § 6; L. 1976, ch. 273, § 3; Feb. 13.

65-2807. License presumptive evidence of right to practice. Every license issued under this act shall be presumptive evidence of the right of the holder to practice that branch of the healing arts and only such branch as is specified therein. The records of the board shall reflect the type of license issued to each applicant.

History: L. 1957, ch. 343, § 7; L. 1976, ch. 273, § 4; Feb. 13.

of medicine or surgery or any of their branches.

(b) Persons who prescribe, recommend or furnish medicine or drugs, or perform any surgical operation of whatever nature by the use of any surgical instrument, procedure, equipment, or mechanical device for the diagnosis, cure or relief of any wounds, fractures, bodily injury, infirmity, disease or physical or mental illness, of human beings.

(c) Persons who attach to their name the title M.D., surgeon, physician, physician and surgeon, or any other word or abbreviation indicating that they are engaged in the treatment or diagnosis of ailments, diseases or injuries of human beings.

History: L. 1957, ch. 343, § 69; L. 1969, ch. 299, § 14; L. 1976, ch. 273, § 30; Feb. 13.

Research and Practice Aids:

Physicians and Surgeons⇐6(1).
Hatcher's Digest, Physicians and Surgeons §§ 1, 2.
C.J.S. Physicians and Surgeons §§ 10, 23.

Law Review and Bar Journal References:

Mentioned in "Guideline for Joint Policy Statement on Nursing Service," 69 J.K.M.S. 66, 67 (1968).
Mentioned in "Legislative Review of Examining and Licensing Functions of State Boards and Commissions," Stanley D. Elofson, 7 W.L.J. 307, 311 (1968).

CASE ANNOTATIONS

1. Acupuncture does not constitute surgery. Acupuncture Society of Kansas v. Kansas Bd. of Healing Arts, 226 K. 639, 645, 602 P.2d 1311.

65-2870. Persons deemed engaged in practice of osteopathy. For the purpose of this act the following persons shall be deemed to be engaged in the practice of osteopathy or to be osteopathic physicians and surgeons:

(a) Persons who publicly profess to be osteopathic physicians, or publicly profess to assume the duties incident to the practice of osteopathy, as heretofore interpreted by the supreme court of this state, shall be deemed to be engaged in the practice of osteopathy.

(b) Osteopathic physicians and surgeons shall mean and include those persons who receive a license to practice medicine and surgery pursuant to the provisions of this act.

History: L. 1957, ch. 343, § 70; L. 1969, ch. 299, § 15; L. 1976, ch. 273, § 31; Feb. 13.

Law Review and Bar Journal References:

Mentioned in "Legislative Review of Examining and Licensing Functions of State Boards and Commissions," Stanley D. Elofson, 7 W.L.J. 307, 311 (1968).

65-2871. Persons deemed engaged in practice of chiropractic. For the purpose of this act the following persons shall be deemed to be engaged in the practice of chiropractic: (a) Persons who examine, analyze and diagnose the human living body, and its diseases by the use of any physical, thermal or manual method and use the X-ray diagnosis and analysis taught in any accredited chiropractic school or college and (b) persons who adjust any misplaced tissue of any kind or nature, manipulate or treat the human body by manual, mechanical, electrical or natural methods or by the use of physical means, physiotherapy (including light, heat, water or exercise), or by the use of foods, food concentrates, or food extract, or who apply first aid and hygiene, but chiropractors are expressly prohibited from prescribing or administering to any person medicine or drugs in materia medica, or from performing any surgery, as hereinabove stated, or from practicing obstetrics.

History: L. 1957, ch. 343, § 71; L. 1976, ch. 273, § 32; Feb. 13.

Research and Practice Aids

Physicians and Surgeons⇐6(1).
Hatcher's Digest, Physicians and Surgeons §§ 1, 2.
C.J.S. Physicians and Surgeons §§ 10, 23.

Law Review and Bar Journal References:

Mentioned in "Legislative Review of Examining and Licensing Functions of State Boards and Commissions," Stanley D. Elofson, 7 W.L.J. 307, 311 (1968).

CASE ANNOTATIONS

1. State recognizes practice of chiropractic as one of the healing arts. Taylor v. Maxwell, 197 K. 509, 511, 419 P.2d 822.

2. Acupuncture does not constitute surgery and is not prohibited in the practice of chiropractic. Acupuncture Society of Kansas v. Kansas Bd. of Healing Arts, 226 K. 639, 643, 645, 646, 647, 602 P.2d 1311.

65-2872. Persons not engaged in the practice of the healing arts. The practice of the healing arts shall not be construed to include the following persons:

(a) Persons rendering gratuitous services in the case of an emergency.

(b) Persons gratuitously administering ordinary household remedies.

(c) The members of any church practicing their religious tenets provided they shall not be exempt from complying with all public health regulations of the state.

(d) Students while in actual classroom attendance in an accredited healing arts school who after completing one (1) year's

study treat diseases under the supervision of a licensed instructor.

(e) Students upon the completion of at least three (3) years study in an accredited healing arts school and who, as a part of their academic requirements for a degree, serve a preceptorship not to exceed ninety (90) days under the supervision of a licensed practitioner.

(f) Persons who massage for the purpose of relaxation, muscle conditioning, or figure improvement, provided no drugs are used and such persons do not hold themselves out to be physicians or healers.

(g) Persons whose professional services are performed under the supervision or by order of or referral from a practitioner who is licensed under this act.

(h) Persons in the general fields of psychology, education and social work, dealing with the social, psychological and moral well-being of individuals and/or groups provided they do not use drugs and do not hold themselves out to be the physicians, surgeons, osteopathic physicians or chiropractors.

(i) Practitioners of the healing arts in the United States army, navy, air force, public health service, and coast guard or other military service when acting in the line of duty in this state.

(j) Practitioners of the healing arts licensed in another state when and while incidentally called into this state in consultation with practitioners licensed in this state, or residing on the border of a neighboring state, duly licensed under the laws thereof to practice a branch of the healing arts, but who do not open an office or maintain or appoint a place to regularly meet patients or to receive calls within this state.

(k) Dentists practicing their professions, when licensed and practicing in accordance with the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated, or amendments thereto, and any interpretation thereof by the supreme court of this state.

(l) Optometrists practicing their professions, when licensed and practicing under and in accordance with the provisions of article 15 of chapter 65 of the Kansas Statutes Annotated, or amendments thereto, and any interpretation thereof by the supreme court of this state.

(m) Nurses practicing their profession when licensed and practicing under and in accordance with the provisions of article 11 of chapter 65 of the Kansas Statutes Annotated, or amendments thereto, and any interpretation thereof by the supreme court of this state.

(n) Podiatrists practicing their profession, when licensed and practicing under and in accordance with the provisions of article 20 of chapter 65 of the Kansas Statutes Annotated, or amendments thereto, and any interpretation thereof by the supreme court of this state.

(o) Every act or practice falling in the field of the healing art, not specifically excepted herein, shall constitute the practice thereof.

(p) Pharmacists practicing their profession, when licensed and practicing under and in accordance with the provisions of article 16 of chapter 65 of the Kansas Statutes Annotated, or amendments thereto, and any interpretation thereof by the supreme court of this state.

(q) A dentist licensed in accordance with the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated who administers general and local anesthetics to facilitate medical procedures conducted by a person licensed to practice medicine and surgery if such dentist is certified by the board of healing arts under K.S.A. 65-2899 to administer such general and local anesthetics.

History: L. 1957, ch. 343, § 72; L. 1976, ch. 273, § 33; L. 1976, ch. 276, § 2; July 1.

Research and Practice Aids:

Hatcher's Digest, Physicians and Surgeons §§ 1, 2.

Law Review and Bar Journal References:

Mentioned in "Guideline for Joint Policy Statement on Nursing Service," 69 J.K.M.S. 66, 67 (1968).

Discussed in "Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform," Philip C. Kissam, 24 K.L.R. 1, 12, 22, 23, 26, 27 (1975).

Referred to in "Recent Legislation: The Kansas Approach to Medical Malpractice," Nancy Neal Scherer and Robert P. Scherer, 16 W.L.J. 395, 407 (1977).

CASE ANNOTATIONS

1. Mentioned; terms "physician" and "qualified medical technician" as used in 8-1003 interpreted. State v. Carter, 202 K. 63, 66, 446 P.2d 759.

2. Cited; practice of healing arts does not include those whose services are performed under supervision of a licensed practitioner. State, *ex rel.*, v. Doolin & Shaw, 209 K. 244, 257, 497 P.2d 138.

3. Subsection (g) cited; right of physician to referral recognized. State, *ex rel.*, v. Doolin & Shaw, 209 K. 244, 262, 497 P.2d 138.

65-2873. License to practice healing

STATE OF KANSAS

Office of the Attorney General

1st Floor, State Capitol Bldg. (913) 296-2215 Topeka, Kansas 66612

Curt T. Schneider
Attorney General

May 17, 1978

ATTORNEY GENERAL OPINION NO. 78-164

Mr. Michael J. Malone
Douglas County Attorney
Judicial and Law Enforcement Center
Lawrence, Kansas 66044

Re: I. Public Health--Healing Arts--Unlawful Practice of Healing Arts: Midwifery

II. Crimes and Punishments--Crimes Against Persons--Involuntary Manslaughter; Aiding and Abetting

Synopsis: 1. The practice of midwifery is a *per se* violation of the Kansas Healing Arts Act, K.S.A. 65-2801, *et seq.*

2. A fetus unintentionally killed without malice in the commission of a violation of the Kansas Healing Arts Act is a violation of K.S.A. 21-3404: involuntary manslaughter.

3. Any person who intentionally aids, abets, advises, hires, counsels or procures midwives to practice obstetrics may be charged with involuntary manslaughter.

* * *

Dear Mr. Malone:

I have your letter of March 14, 1978, wherein you request the opinion of this office concerning the legality of persons performing services generally referred to as midwifery, or assisting pregnant women in childbirth. You advise that certain women in Douglas County hold themselves out to the public as midwives and have in fact assisted with more than one home childbirth, although they possess no formal medical training regarding such practice.

First, you specifically inquire whether the provisions of the Healing Arts Act, K.S.A. 65-2801, *et seq.* and as amended, prohibit the practice of midwifery by nonlicensed persons.

K.S.A. 1977 Supp. 65-2802 provides thus:

> "For the purpose of this act the following definitions shall apply:
> (a) The healing arts include any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, or injury, *and includes* specifically but not by way of limitation *the practice of medicine and surgery*; the practice of osteopathic medicine and surgery; and the practice of chiropractic." [Emphasis supplied.]

K.S.A. 1977 Supp. 65-2869 further amplifies the foregoing provision thus:

> "For the purpose of this act the following persons shall be deemed to be engaged in the practice of medicine and surgery:
> (a) Persons who publicly profess to be physicians or surgeons, or *publicly profess to assume the duties incident to the practice of medicine* or surgery *or any of their branches.*" [Emphasis supplied.]

K.S.A. 65-2803 also provides:

> "No person shall engage in the practice of any branch of the healing arts, as hereinafter defined, unless he shall have obtained from the board a license for that purpose."

As relates to the facts alleged in your letter the proscription of these statutes is clear: individuals not licensed under the

Act may not engage in activities which entail duties incident to the practice of medicine or any of its branches. Thus, the question necessarily presented is whether assisting at childbirth or practicing midwifery is tantamount to the practice of a branch of medicine or, in other words, a branch of the healing arts.

"Midwifery" is defined by *Webster's New Third International Dictionary* as:

> "1: the act of assisting at childbirth; *also* obstetrics . . . ."

The term "obstetrics" is defined by the same source as:

> "a branch of medical science that deals with birth and with its antecedents and sequels."[1]

That obstetrics or midwifery has long been recognized as a branch of medicine is evident from the following observation of the Supreme Judicial Court of Massachusetts:

> "Both medical and popular lexicographers define midwife as a female obstetrician, and midwifery as the practice of obstetrics.
>
> * * *
>
> Although childbirth is not a disease, but a normal function of women, yet the practice of medicine does not appertain exclusively to disease, *and obstetrics as matter of common knowledge has long been treated as a highly important branch of the science of medicine.*" [Emphasis supplied.] *Commonwealth v. Porn*, 196 Mass. 326, 82 N.E. 31 (1907).

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1. *See, Stedman's Medical Dictionary* definitions for "midwifery" and "obstetrics," pp. 1004 and 1105 respectively.

Accord, Bowland v. Municipal Court for Santa Cruz County, Etc., 134 Cal.Rptr. 630, 556 P.2d 1081 (1977).

It is the opinion of this office therefore that an individual who assists with childbirth and who holds himself or herself out to the public as offering such assistance is overtly assuming the duties incident to the practice of a branch of medicine and thus a branch of the healing arts, *i.e.*, obstetrics, and must accordingly hold the requisite license per K.S.A. 65-2803. To the extent that such activities are *per se* violations of the express language of the Act, it is not necessary to determine the effects of gratuitous midwife services or the nontrained medical status of the midwives. Nor does it appear necessary to address the exception to the act for gratuitous services in emergency situations provided at K.S.A. 1977 Supp. 65-2872(a).

You also ask what, if any, remedies exist in this Act regarding the unauthorized practice of healing arts aside from the injunction and quo warranto provisions of K.S.A. 1977 Supp. 65-2857. Your attention is directed to criminal charges which may be filed under K.S.A. 65-2862 which states:

> "Any person violating any of the provisions of this act, except as specific penalties are herein otherwise imposed, shall be deemed guilty of a misdemeanor and upon conviction thereof shall pay a fine of not less than fifty dollars ($50) nor more than two hundred dollars ($200) for each separate offense, and a person for a second violation of any of the provisions of this act, wherein another specific penalty is not expressly imposed, shall be deemed guilty of a misdemeanor and upon conviction thereof shall pay a fine of not less than one hundred dollars ($100) nor more than five hundred dollars ($500) for each separate offense."

Last, you ask concerning the applicability of K.S.A. 21-3404 to the situation which involves the midwives as previously discussed, where the fetus dies as a result of "such a practice," *i.e.* the activities of the midwives. K.S.A. 21-3404 provides thus:

> "Involuntary manslaughter is the unlawful killing of a human being, without malice, which is done unintentionally in the commission of an unlawful act not amounting to felony, or in the commission of a lawful act in an unlawful or wanton manner. As used in this section, an 'unlawful act' is any act which is prohibited by a statute of the United States or the state of Kansas or an ordinance of any city within the state which statute or ordinance is enacted for the protection of human life or safety.
>
> Involuntary manslaughter is a class E felony."

As opined, *supra*, practicing midwifery without the required license from the Board of Healing Arts is the commission of an unlawful act not amounting to felony. If the fetus under the circumstances you describe was in fact unintentionally killed without malice in the commission of the unlawful act, then it appears reasonable to conclude that the midwives and husband (if he was so involved) may be charged with involuntary manslaughter. Insofar as concerns the pregnant woman who attempted to give birth to the fetus, if she "intentionally aids, abets, advises, hires, counsels or procures" the husband or midwives to practice midwifery or obstetrics, then she likewise may be charged with violating K.S.A. 21-3404, pursuant to K.S.A. 21-3205.

Of course, the decision to prosecute for any of the above or similar acts must rest with the local prosecutors and their assessment of the specific facts presented to them.

Yours truly,

Curt T. Schneider

CURT T. SCHNEIDER
Attorney General

CTS:JPS:kj

IN THE DISTRICT COURT OF FINNEY COUNTY, KANSAS

STATE OF KANSAS EX REL.
KANSAS STATE BOARD OF HEALING ARTS
BY JAY C. HINKEL, FINNEY COUNTY ATTORNEY, Plaintiff,

vs. Case No. 84 C 238

LYNDA J. HITCHCOCK, Defendant.

ORDER

NOW on this 15th day of November, 1984, this matter comes on for hearing. Plaintiff is present by Jay C. Hinkel, Finney County Attorney and Donald G. Strole, general counsel for the Kansas Board of Healing Arts. Defendant is present by her attorney, Richard H. Seaton.

Thereupon the parties announce to the court that they have settled the differences between them and have agreed upon findings to be entered by the court as follows:

1. A midwife is a person who assists women in childbirth. Defendant has engaged in the practice of midwifery in the past, and desires to do so in the future, in the State of Kansas.

2. Defendant's training in this field includes a nine-week course in Odessa, Texas, a correspondence course in the State of Texas, and attendance at 23 births with a senior midwife. She has also assisted at approximately 75 births as the principle midwife.

3. When she takes on a client, defendant presents the client with literature detailing her practices and describing the possible complications which may arise during pregnancy and childbirth. She continues to so advise them during the course of their pregnancy.

4. Defendant is a member of the Kansas Midwives Association.

5. She also attends seminars and subscribes to publications on the subject of midwifery.

6. It is the defendant's normal practice to have a licensed physician, normally the client's own physician, who has agreed to be available in case of complications and to be available for consultation and examination upon defendant's request.

7. The defendant does not present herself to parents or others as being a physician or a surgeon, and does not attach any title to her name such as M.D., Surgeon, Physician, or Physician and Surgeon.

8. Except for certain vitamins, teas and herbs, she does not recommend anything for the mother to take internally.

9. She does not employ sutures, perform episiotomies, or use forceps. She does aspirate the baby after birth and clamp and cut the unbilical cord after birth.

Further, the parties announce to the court that they have agreed upon the following order to be entered by the court.

1. Defendant shall be permitted to engage in the practice of midwifery in the State of Kansas, and such practice shall not be considered the practice of healing arts or the practice of medicine and surgery, so long as she utilizes a licensed physician in the vicinity who has agreed to be available in case of complications and to be available for consultation and examination, and so long as she will provide such physician with her prenatal records of the patient in the event the physician so requests prior to delivery.

2. The plaintiff Board of Healing Arts shall, prior to December 1, 1984, notify the Kansas Medical Society and Kansas Association of Osteopathic Medicine of the contents of this order, and further shall notify all doctors of medicine and all doctors of osteopathy licensed by it of the contents of this order no later than July 15, 1985, all such notices to be in writing.

The court, having heard the statements of counsel, and being duly advised in the premises, finds that the findings and order agreed upon by the parties should be adopted as the findings and order of the court.

IT IS SO ORDERED.

The Honorable Phillip C. Vieux
Associate District Judge

APPROVED:

Jay C. Hinkel
Finney County Attorney

Donald G. Strole
Attorney for the Kansas Board of Healing Arts

Richard H. Seaton
Attorney for Defendant

Lynda J. Hitchcock
Lynda J. Hitchcock

Richard A. Uhlig, D.O.
Secretary for the Kansas State Board

FILED
CLERK DISTRICT COURT
FINNEY CO. KANS.
'84 NOV 15 PM 2 44
DIANA JONES
BY

(2) SB-125 Abby Horak - 2-18-85

KSNA

the voice of Nursing in Kansas

Statement Before the Senate
Public Health and Welfare Committee
February 18, 1985

Mr. Chairman and members of the Committee. I speak in opposition to SB 125.

My name is Abby Horak, I am a community health nurse and nurse practitionor with Lyon County Health Dept.. I represent both the Kansas State Nurses Association and its Advanced Practice Conference Group.

This bill is unsound in many ways. My primary objection is because the results of this bill would be misleading. To license lay midwives would invest in their title a credibility that does not exist. It would be misleading to the public who would assume the lay midwife licensee was adequately and appropriately prepared to safely provide prenatal care and attend a home delivery. Such is not the case. Consumers would be led to believe that the state has designated these persons as safe.

The bill allows important decisions, especially of education and supervision, to be decided by a council whose own qualifications have not been established. In fact, there are no educational requirements included and the bill implies that apprenticeship may be adequate training.

The Kansas State Nurses Association's legislative position includes support for those bills which implement safegiards for the rights of all citizens. Licensing lay midwives places some citizens in jeopardy. The poor or the working poor might utilize lay midwives as a cost-saving measure even though it might be unsafe. A child born in the home setting is exposed to potential complications without immediate, trained help nor adequate facilities.

2/18/85
Attachment II

In listening to testimony last week I was struck by the inconsistencies and confusion. The proponents of SB 125 say lay midwives are not health care providers. The bill specifically states the lay midwife will provide health care including "detection of abnormal conditions in the mother and child" and "the execution of emergency measures in the absence of medical help."

Home births can be attended by physicians and nurse midwives. The statistics from Sweden and the Netherlands and from Kentucky Frontier Nursing Service that demonstrate safety in home delivery fail to note that the midwives are not lay persons but rather certified nurse midwives.

As a community health nurse, I am in daily contact with persons who are in a "money crunch". Many would fail to appreciate the dangers of home birth attended by persons who have little or no education and training. Many are also those at greatest risk for increased morbibity and mortality. A bill like this can only increase their risks.

Please reject this piece of legislation. Thank you for the opportunity to speak.

(3) SB-125 Janice Noyes 2-18-85

Testimony before the Public Health and Welfare Committee of the Kansas Senate in Opposition of SB 125. February 18, 1985

Mr. Chairman and Committee Members:

I speak in oppósition of SB 125.

My name is Janice Noyes. I have been a registered nurse in Kansas for 13 years. For the past seven and a half years I have been practicing with a private obstetrician and gynecologist in Emporia. In 1982 I was certified by the Nurses Association of American College of Obstetricians and Gynecologists as a nurse practitioner and I am licensed as such by the Kansas State Board of Nursing in the specialty area of obstetrics and gynecology. I am also an active member of the American Nurses Association and the Kansas State Nurses Association.

I have worked in the area of obstetrics giving both pre- and post-natal nursing care to mothers and babies. I have also been involved in various community activities to see that all pregnant women receive quality, safe affordable care. I consider myself a consumer advocate and my involvement in my professional organizations and activities illustrates that I am concerned about standards of health care for Kansas Citizens.

Before coming to speak before you today, I spent several hours of study on this bill. The implications of SB 125 for the citizens of Kansas are frightening. There is nothing in this bill which addresses standards—Standards of practice, Standards of educational preparation, standards of testing and there is no mention or rules and regulations other than they will be established by the council if the skill of the

2/18/85
Attachment III

attendant is integral to the successful outcome of the birth, then why are there no standards addressed in this bill. This fact coupled with the fact that lay individuals propose to designate themselves as legitimate care-givers is unsafe.

Proponents of SB 125 will argue that medical and nursing interventions are unnatural and invasive. The issue here is not what is natural, but what is safe. Comfort does have to be conceded at times to the inconcenience of medical technology to insure the safety and well-being of the mother and baby. Last week, proponents of SB 125 stated that rights of the birthing family are not being met. Every expectant family has a right to safe care during the maternity cycle and it cannot be obtained by the licensing of lay persons with limited educational background and limited clinical skills.

Proponents of this bill will also argue that consumers want home deliveries and they are being denied the right to a home birth. As stated by Ms. Horak, there is nothing in Kansas law prohibiting a physician or nurse-midwife from delivering in the home. However, medical and nursing professionals have stringent criteria which must be met for a successful home birth experience.

For example: The expectant mother must undergo a thorough physical examination with laboratory studies to completely assess her health status. Lay midwives have no access to facilities to obtain necessary lab results. The care of the mother and baby would be incomplete.

The expectant family must be assessed for psycho-social and socio-economic problems as well as for the level of understanding of the maternity cycle

and the birth process. Other factors including maternal age, weight, histories of previous labors and deliveries, multiple pregnancy must be taken into consideration. A family desiring home birth must be constantly evaluated and counselled in all these areas. Lay midwives lack the theoretical background and clinical practice to even minimally assess these needs.

Lay midwife proponents have stressed that pregnancy and delivery are very natural and normal processes. In most cases this is true. However, any professional care-giver in obstetrics can tell you that the abnormal usually presents itself in two ways: Subtly as to be almost unrecognizable, or suddenly as to be tragic. Medical intervention is needed immediately in these emergencies to save both the mother and baby's lives. Lay persons have no immediate access to medical care and are in no way capable of handling such disastrous events. This bill addresses entrusting the care of both mothers and fetuses to lay individuals during the maternity cycle. But more important it deals with life itself. We cannot gamble with the lives of expectant mothers and the lives and/or potentials of their unborn.

I believe passage of SB 125 would mean just that. Safe care means complete care, not just "necessary care" as stated in this bill. Lay persons or "midwives" have no right to present themselves as qualified care-givers. Respectfully I urge you to consider the safety of Kansas in this issue and refuse to recognize lay midwives as legitimate care givers.

Thank you.

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601
Telephone 913/296-4929

TO: The Honorable Roy Ehrlich, Chairman, and Members of the Senate Public Health and Welfare Committee

FROM: Lois Rich Scibetta, Ph.D., R.N.
Executive Administrator

DATE: February 14, 1985

RE: Senate Bill 125

Thank you Mister Chairman. I appreciate the opportunity to comment on Senate Bill 125. This Bill has been introduced for the last four sessions, and has been consistently opposed by the Board of Nursing. The Board is still opposed to the licensure of lay-midwives, because it may endanger the public health, safety and welfare of Kansans.

For the last several years, this has been an emotional issue. There is not any doubt that lay-midwives have made a contribution. Some proponents of the licensure of lay-midwives relate the licensure of lay-midwives to the individual right to have a home delivery. The issue is not the right to have home births per se, but rather, that those in attendance at the birth are knowledgeable, adequately prepared, and that they are capable of handling emergencies appropriately, and with dispatch. It should be noted that in 1984, an infant death occurred following a delivery attended by a lay-midwife.

It should also be noted that home births are possible, and some physicians and nurse-midwives do attend these births.

There are several Sections of the Bill which are not specific which give the Board serious concern - Line 0030 under definition "trained" is not defined. Where would this "training" occur, who would approve and supervise the educational program? Would a correspondence course be considered training? Section 4. Regulatory Council. Why are the members appointed by the Secretary. The current Secretary is a nurse and she is aware of the inherent dangers. What happens when a new Governor appoints a new Secretary? Does the Department of Health and Environment license individuals? The precedent is questionable. In addition this would generate more bureauracy and cost to the State.

Section 6. Provisional license. Before an exam is prepared and given? All licensees in Kansas pass an examination before licensure. This is to protect the public. It is time cosuming and costly to generate an examination. It is a dangerous precedent to license before examination.

2/18/85
Attachment IV

Related to licensure, it is my understanding that any health related occupation/group desiring certification or licensure must first approach the State Health Coordinating Council, a part of the Department of Health and Environment. It does not appear that this procedure was followed.

The Board recognizes the fact that lay-midwives have made important contributions in some areas of the country, however it cannot recommend the licensure of this group. Kansas is a rural state. The complications which might, and do, occur during delivery require physician back-up assistance in order to offer the mother and child the best possible care. Hospital facilities must be available. Lay-midwives would not have access to the hospital.

In summary, the Board urges the Committee to vote against this Bill in order to protect the public health, safety and welfare of the citizens of Kansas.

Thank you for this opportunity to speak on behalf of the Board. I will be happy to answer any questions which you may have. Thank you.

LRS/amm

SB-125 - Harold Riehm 2-18-85

Kansas Association of Osteopathic Medicine

TESTIMONY OF THE KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE ON S.B. 125

My name is Harold Riehm and I represent the osteopathic physicians practicing in Kansas. I appear today to oppose S. B. 125. Our opposition is based on the following points.

First, Kansas has established a fair and thorough procedure within the Statewide Health Coordinating Council, by which providers of health care services may seek license credentialing review. We think this is the appropriate place for a review to be made of the aspirations of midwives practicing in Kansas. We also feel that the contention of midwives that they are a consumer group is neither correct nor justifiable reason for circumventing the established review process within SHCC.

Second, we agree with the finding by The Kansas Board of Healing Arts that the practice of midwifery does involve the practice of medicine and that, in the case of midwives, these obsterical services should be conducted only under the supervision of a licensed physician. There is certain irony in physicians being confronted with rapidly increasing malpractice premiums for the practice of obstetrics because of its "high risk" category of health care, and the contention of midwives that their practice does not constitute the practice of medicine.

KAOM emphasizes that there is no such thing as a totally predictable birth delivery. Complications can and do occur. A "non-invasive" approach may be used by midwives, but there are instances when invasion is required. They may claim to bring the hospital into the home, but is without the many emergency equipment and personnel within the hospital setting.

We think these are compelling reasons that this whole question be examined by SHCC and that is what we urge the Committee to recommend.

Thank you for this opportunity to appear before you.

2/18/85
Attachment VI

(6)

SB-135 - 2-14-83

Report to the 1979 Legislature

RE: PROPOSAL NO. 20 - MIDWIFERY

Pursuant to the directives of Proposal No. 20, the Special Committee on Public Health and Welfare studied the desirability of state recognition of the practice of midwifery and the regulation thereof.

The Committee considered this proposal at several meetings and heard a number of individuals and representatives of organizations on the issues involved in authorizing the independent practice of midwifery. Representatives of the P.E.A.C.E. & H.O.M.E. Association of Wichita, of the Lawrence Association of Parents and Professionals for Safe Alternatives in Childbirth, of the Association for Childbirth at Home International, of the Kansas State Nurses Association, of the State Board of Nursing, of the Kansas Obstetrical and Gynecological Society, and of the Kansas Medical Society met with the Committee. In addition, a certified nurse midwife and several individuals who had experienced home births appeared and presented statements.

Practice of Midwifery

In general, the practice of midwifery is the care of mothers and babies through the maternity cycle — the prenatal care, delivery and postnatal care of the mother along with care of the newborn — by an individual who is not a physician.

The midwife may be a lay person with no specific training in the care of pregnant women and newborns, a lay person who has received some training in midwifery and who has passed an examination certifying that she is qualified to provide care for uncomplicated pregnancies, or a registered professional nurse who has graduated from an approved school of nurse midwifery and who has successfully completed a national certificate examination which allows the nurse to use the title "Certified Nurse Midwife."

Although at one time the care of pregnant women and the newborn was almost exclusively carried out by lay midwives, the practice of lay midwifery declined in the United

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States from 20,700 lay midwives reported as practicing in 1948 to 2,880 reported as practicing in 1972, the most recent year for which data are available.* Well over half the lay midwives reported as practicing in 1972 were located in Texas, Alabama and Mississippi.

While the practice of midwifery by lay persons has declined, the development of the trained professional nurse midwife has taken place. The American College of Nurse Midwives was established in 1955, and in 1971 the practice of nurse-midwifery was officially recognized and sanctioned by the American College of Obstetricians and Gynecologists. Presently, 23 states or territories enable the practice of nurse-midwifery through legislative action and nine additional states authorize such practice through regulations or joint practice statements. The nurse midwife usually practices, under a protocol or written agreement, with a physician who is available for consultation or, in the case of complications, assists with the pregnancy or birth.

Issues

In the course of its study, the Committee discovered that many of those who support the licensing and regulation of midwifery do so because they believe that alternatives to the traditional care of pregnant women should be available to those who choose them. Home births, as opposed to an institutional setting; a non-medical model of care characterized as treating pregnancy and delivery as normal processes rather than illness; greater family involvement in delivery; and more immediate and prolonged contact and bonding between parents and child than is customary in the traditional institutional setting were those alternatives most frequently noted by conferees.

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* Source: Health Resources Statistics, Department of Health, Education and Welfare, 1974.

Other issues which were identified in conjunction with consideration of authorizing the practice of midwifery were: the degree of education and training which should be required of the practitioner, the degree to which midwifery should constitute an independent practice of health care, the type of regulatory authority which should be given the responsibility for determining competence to practice, and the availability of training for midwives.

Conclusions and Recommendations

The Committee notes the concerns of those persons who believe that alternatives to the generally accepted practice of maternity and newborn care should be available to those who, after careful consideration, choose such alternatives. The Committee also notes that, while attitudinal and institutional changes may not be sufficiently widespread and may fall short of meeting the demands of those who desire alternatives, there is some evidence of such institutional and attitudinal change in the development of "birthing rooms" in larger hospitals in Kansas, in the position statements of health care professionals in regard to family-centered maternity care, and in the development of the team approach to maternity care which utilizes the skills of non-physicians to provide information, counseling and care for the pregnant woman and her family.

The Committee feels that any recommendation relative to the licensing of lay midwives is premature. The Committee does not recommend changes in existing laws which would authorize the practice of midwifery by unlicensed persons. In reaching this decision, the Committee notes that two primary factors influenced the decision.

One factor was the legislation enacted by the 1978 Legislature which requested the Statewide Health Coordinating Council to make a study of the credentialing of health care providers and to report the results of such study to the 1979 Legislature. The Committee believes that no new health care providers should be licensed or otherwise credentialed until the Legislature has had an opportunity to review

the Statewide Health Coordinating Council's report and to act on the recommendations contained therein.

The second factor which influenced the Committee's recommendation was the action taken by the 1978 Legislature in amending the laws relating to the practice of nursing to authorize the Advanced Registered Nurse Practitioner. This legislation has yet to be implemented by the State Board of Nursing through the adoption of rules and regulations. However, information presented to the Committee by representatives of the Board indicates that one of the first categories of nurse practitioners authorized by rules and regulations will be the registered nurse midwife. The Committee notes that there are presently nurse midwives in Kansas who are certified by the American College of Nurse Midwives and who may be eligible to practice as nurse midwives without further training at such time as the Board of Nursing authorizes their practice. In addition, there are 19 educational programs in the United States which meet accreditation standards for training nurse midwives and, should the decision be made to do so, a program of this type could be implemented in Kansas. The Committee urges the Board of Nursing to proceed as rapidly as possible with the implementation of rules and regulations which recognize the qualified nurse midwife as an Advanced Registered Nurse Practitioner and which authorize qualified professional nurses to practice this specialty.

Respectfully submitted,

November 30, 1978

Sen. Wesley Sowers, Chairperson
Special Committee on Public
Health and Welfare

Rep. Michael G. Johnson,
Vice-Chairperson
Sen. James L. Francisco
Sen. Leroy A. Hayden
Sen. John F. Vermillion
Rep. Arnold Anderson
Rep. Theo Cribbs

Rep. Kenneth Francisco
Rep. Sharon Hess
Rep. Kenneth R. King
Rep. John H. Reimer
Rep. Tom Slattery
Rep. Kathryn E. Sughrue

SB-125-2-1985

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

Senate Public Health and Welfare Committee

February 14, 1985

SB 125; Concerning Midwifery

The Kansas Medical Society appreciates the opportunity to comment on Senate Bill 125, which would legalize the practice of lay midwifery in Kansas. We are opposed to SB 125, and urge you to reject the bill for the following reasons:

1. Several years ago the Legislature established a credentialing program for health care personnel, administered by the State Department of Health and Environment. The credentialing act, found at KSA 65-5001, was set up to objectively review decisions on whether or not to register or license health care personnel. The lay midwives should first go through the credentialing process, as has every other group since the law was enacted, before the Legislature even considers this legislation.

2. Notwithstanding the credentialing requirements above, we also believe that granting the state's seal of approval through licensure to lay midwives is a big step backwards. At a time when the public and regulatory officials are demanding excellence and an extremely high standard of care from health care providers, it would seem inappropriate for the state to promote the delivery of such an essential health service by less well trained individuals. Physicians must complete eight years of training, four years in medical school and at least four years in a residency program, to be allowed by law to do obstetrics in Kansas. This bill sets no

minimun qualifications, and would allow lay midwives currently practicing illegally in the state to develop and supervise the only examination required for eventual licensure.

In the current medical-legal environment, which has made obstetrical practice the highest risk and most costly in terms of liability, we urge the Legislature to act cautiously before granting blanket approval to lay midwives. The whole purpose of regulation and licensure by the state is to assure the citizenry that health care providers are well trained to provide competent care. If you now legalize the practice of lay midwifery, will you also relax the standards for the training of physicians?

We urge you to report SB 125 unfavorably. Thank you for the opportunity to present these comments.

JS:arb

SB-121 Jack Roberts 2-18-85

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

February 15, 1985

Senate Bill 121 -- 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.

2/18/85
Attachment VI

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

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

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 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 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 D

1982 BLUE SHIELD PODIATRISTS

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	$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 C

1982 BLUE SHIELD OPTOMETRISTS

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	$ 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 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 A

1982 BLUE SHIELD CHIROPRACTOR

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	$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

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.

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.

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.

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.

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

*Benefit covered prior to being mandated.

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.

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.

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) (7/1/74)	(1*)BC	1,218,124	----	0.98	
		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.

Received 9/9/84

#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

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

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

#8

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.

TOTAL NUMBER OF STATES WITH MANDATED COVERAGES

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

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

2.1 #

(As of 7-1-84)

#18

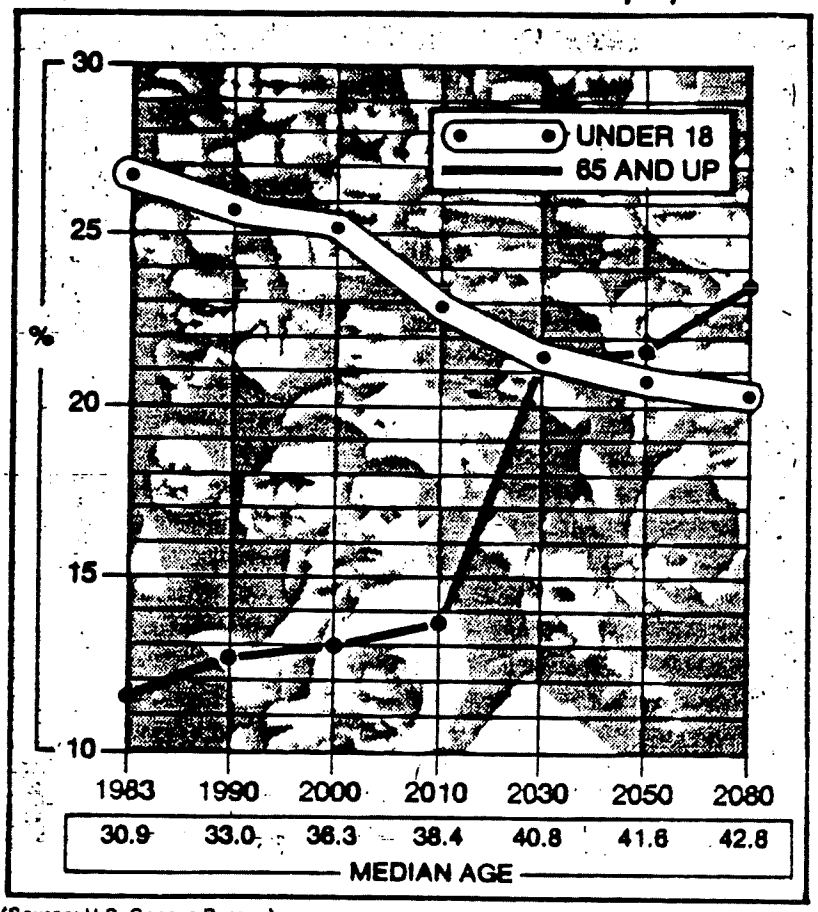
DEMOGRAPHIC REVOLUTION

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.