Approved 2-18-86
Date

MINUTES OF THE House COMMITTEE ON Insurance.

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

3:30 ~~xx~~ a.m./p.m. on February 13, 1986 in room 521-S of the Capitol.

All members were present except:

Committee staff present:

Melinda Hanson, Research Department
Gordon Self, Revisor's Office
Deanna Willard, Committee Secretary

Conferees appearing before the committee:
Mr. Carl Schmitthenner, Kansas Dental Association
Mr. Walt Whalan, Pyramid Life
Mr. Jack Roberts, Blue Cross Blue Shield
Mr. Dick Brock, Kansas Insurance Department
Mr. Wayne Morris, Security Benefit Life

The Chairman called the meeting to order.

Hearing on: House Bill 2496 - An act relating to misrepresentation concerning insurance contracts providing dental coverage.

Melinda Hanson explained that the bill had been requested during the last session by the Kansas Dental Association. It defines certain practices to be misleading for the purposes of disciplinary practices for dentists. It defines forgiveness of a co-payment as a fraudulent act.

Mr. Carl Schmitthenner, Kansas Dental Association, stated that this bill would make it illegal to abrogate co-payments and provide that the offender appear before a peer review board. It also would give an insurance company a means with which to go back on a fraudulent act. (Attachment 1.)

Hearing on: House Bill 2860 - relating to financial impact report required when requesting mandated health insurance coverage.

Melinda Hanson explained that this bill would require that the sponsor of a bill provide a financial and social impact statement. It would give an opportunity for the sponsoring group to do the "balance sheet" and should lead to a more informed committee session.

Mr. Richard Harmon introduced Mr. Walt Whalan, Vice President of Pyramid Life. Mr. Whalan stated that several states have similar legislation and that it allows for a more streamlined process of legislation. He feels that fewer printings would be required as the basic work is done before the bill is submitted to the committee.

There was discussion regarding whose responsibility it would be to prepare the statement and whether each sponsor would need a statement.

Mr. Jack Roberts, Blue Cross Blue Shield, expressed support for the bill saying that it attempts to create an orderly process of legislation. He believes that mandating of health

coverages has contributed to a shrinking base as larger companies self insure. He used exhibits to show the increase in mandated benefits in recent years and the costs involved. He noted the bills before the Legislature which would "mandate increased costs on persons carrying traditional insurance coverage." (Attachment 2.)

Mr. Dick Brock, Kansas Insurance Department, said that the Department does not take a position on bills that mandate coverage as the impact has usually not been determined. However, employers do at times call the Department to complain when they have been required to provide a coverage. He thinks it would be helpful to determine the impact of a mandate in the early stage of the bill as it might be greater than a sponsor anticipated.

Mr. Wayne Morris, Security Benefit Life, requested permission to introduce two bills that would make changes in the law governing deposit of securities. Rep. Lowther made a motion that the bills be introduced; Rep. Gjerstad seconded the motion. (Attachment 3.)

The minutes of the previous meeting were approved.

The meeting was adjourned at 4:45 p.m. by the Chairman.

KDA
KANSAS DENTAL ASSOCIATION

February 13, 1986
House Insurance Committee
HB 2496

This bill was requested by the Kansas Dental Association in response to concerns which were raised by some of the prepaid dental plans.

The problem is that there may be some dentists who are accepting an amount less than their stated fee as payment in full for the services they render. On the surface this sounds like a good situation or a normal discount. The problem is that the dentist may be billing the regular fee to the insurance carrier who has based the actuarial projections with the cost containment impact of a co-pay provision in the contract.

The end result is an unreasonable escalation of dental fees and insurance premiums.

Paragraph 1 is probably obvious, stating that you should not file a false claim.

Paragraph 2 explains that the dentist must bill the insurance company the amount he expects to collect.

Paragraph 3 clarifies that accepting a lesser amount than was actually billed the insurer is fraud.

The Kansas Dental Association supports passage of this bill in order to make it clear that billing a fee other than the usual and customary fee is fraud.

Attachment 1
House Insurance 2/13/86

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

October 17, 1985

TO: Jack Roberts
cc: Don Lynn, Tom Miller, Joe Kun

FROM: Rita Beckner

SUBJECT: MANDATED COVERAGES

Attached are 1984 and 1985 copies of the Mandated Coverages Report. To these reports we have added, under part K, a comment referencing House Bill #2795.

Overall grand totals for the last three years are listed below for comparison. Basically, the differences in grand totals are due to decreases (1984) and increases (1985) in the number of subscribers per year.

The decrease in 1984 was less dramatic than the increase in 1985 because of increases in rates in 1984.

Year	Grand Total
1983	$67,737.363
1984	$66,442,434
1985	$75,204,190

RB:nh
Attachments

Attachment 2
House Insurance 2/13/86

Blue Cross and Blue Shield of Kansas

SECTION I

Page 1

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

Claims Cost to Blue Cross and Blue Shield Subscribers
1984

			Overall Dollars	Per Contract Single	Per Contract Family	Comments
A.	Chiropractors (7/1/73)	(1) BS	$2,794,194	$0.41	$2.06	Coverage became effective 7/1/73.
B.	Dentists (7/1/73)	(1*)BS	954,231	0.25	0.61	Dentist services already covered under Blue Shield same as M.D. prior to being mandated.
C.	Optometrists (7/1/73)	(1) BS	524,958	0.05	0.41	Eye exams had been covered by M.D.'s under Major Medical prior to being mandated.
D.	Podiatrists (7/1/73)	(1*)BS	512,788	0.12	0.34	Podiatrists services already covered under Blue Shield same as M.D.'s prior to being mandated.
E.	Newborn	(1*)BS	394,438	----	0.34	Service was already covered prior to being mandated.
	Infants (I11 Baby Care) (7/1/74)	(1*)BC	928,090	----	0.80	
		Total	1,322,528		1.14	
F.	Psychologists (Direct Reimbursement) (7/1/74)	(1*)BS	157,391	0.36	0.56	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.

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

Claims Cost to Blue Cross and Blue Shield Subscribers
1984

		Overall Dollars	Per Contract Single	Per Contract Family	Comments
G. Well Baby Care	(1*)BS	$ 464,045	$----	$0.40	Blue Shield coverage became effective 1/1/78; hospital services were covered prior to 1/1/78.
	(1*)BC	3,132,302	----	2.70	
	Total	3,596,347	----	3.10	
H. Obstetrical Benefits on Single Contracts	(1*)BS	650,926	0.66	----	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	2,869,990	2.91	----	
	Total	3,520,916	3.57	----	
I. Remove OB Waiting Periods	(1) BS	1,933,372	0.29	1.42	The offering of this benefit, along with single OB coverage, was mandated for groups of 15 or more during 1979.
	(1) BC	3,088,299	0.52	2.22	
	Total	5,021,671	0.81	3.64	

(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

1984

		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	$6,614,119	$2.06	$3.95	House Bill 2693 requires the offering of the first 30 days of in-patient care limited to same as a daily round.
	(1*)BS	4,996,824	1.42	3.10	
	(covered same as daily round)				
	(3) BS(psychiatric charges above daily round)	2,124,837	0.59	1.33	
	Total	13,735,780	4.07	8.38	
	2. 31 to 120 Days				
	(3*)BC	$1,573,768	0.49	0.94	
	(3*)BS(covered same as daily round	1,580,723	0.45	0.98	
	(3) BS(psychiatric charges above daily round)	684,497	0.20	0.42	
	Total	3,838,988	1.14	2.34	
K. Outpatient Psychiatric Services	(3) Basic rider (Full)	11,262,371	3.75	6.52	Assumes coverage at same level as basic coverage. House Bill 2693 requires the offering of a rider to basic which covers out-patient care for the first $100 in full, then 80% up to total payout of $500; the cost of this rider is $~~[illegible]~~ 891,983.
					House Bill 2795 requires the addition of $500 maximum Psychiatric Outpatient Services for all contracts; the cost of this rider is $4,850,067.

(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
1984

		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)	**$11,233,200	$19.01	$56.07	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
1984

			Overall Dollars	Per Contract Single	Per Contract Family	Comments
N.	Physical Therapists	(3) BS	$2,454,315	$0.63	$1.58	Initial monthly cost was provided by the Consulting Actuary.
		(3*)BC	367,189	0.09	0.24	
			2,821,504	0.72	1.82	
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)	$ 176,925	$0.05	$0.11	Assumes such services and facilities are available.
S.	Full coverage in State Mental Hospitals	(3) BC	3,213,666	1.00	1.92	To increase current coverage to Full for 365 days.
T.	Licensed clinical Social Workers billing without physician's referral	(1*)BS	57,817	0.08	0.25	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
1984

			Overall Dollars	Per Contract Single	Per Contract Family	Comments
U. Chronic Renal Disease Coverage for 1st 12 months	(1)	BC	$ 451,500	$2,508.00	----	Coverage effective 10/1/81.
	(1)	BS	123,500	683.00	----	
		Total	574,500	3,191.00	----	
V. TEFRA - standard group coverage (excluding Medicare) for employed persons over age 65	(1)	BC	638,945	72.69	----	Coverage effective 9/1/83 for employees age 65 to 69.
	(1)	BS	483,714	55.03	----	
		Total	1,122,659	127.72	----	
Grand Total			66,442,434			
Grand Total that has been Mandated or may be Mandated that was not covered prior to being Mandated						
Including Item M			41,187,793			
Excluding Item M			29,954,593			

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

* Benefit covered prior to being mandated.

Exhibit A

1983 BLUE SHIELD CHIROPRACTOR

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1983 Incurred As Paid Thru 3-31-84 Single	Family	Unpaid Factors	Estimated Incurred Single	Family
Basic	$191,410.37	$ 440,726.14	1.026	$ 196,387.04	$ 452,185.02
X-Ray	56,689.76	90,622.47	1.026	58,163.69	92,978.65
Lab	1,933.90	2,955.08	1.026	1,984.18	3,031.91
Supplemental Accident	628.80	3,407.77	1.026	645.15	3,496.37
Miscellaneous*	59,355.75	273,749.03	1.026	60,899.00	280,866.50
Major Medical	303,900.85	436,239.07	1.610	489,280.37	702,344.90
Large First-Dollar Major Medical	283,050.26	913,450.77	1.250	353,812.83	1,141,813.46
National Joint Major Medical	16,840.33	66,779.79	1.487	25,041.57	99,301.55
Plan 65 and Disabled	24,617.31	00.00	1.022	25,158.89	00.00
Total	$938,427.33	$2,227,930.12		$1,211,372.72	$2,776,018.36

	Si	Fa
1. 1983 Contract Months	3,188,806	1,461,865
2. 1983 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)	$ 0.38	$ 1.90
3. 1984 Projected Pure Premium (Trends = 1.086)	$ 0.41	$ 2.06

Exhibit B

Mandated Coverages (Dentists)

		Single	Family
1.	1984 rates for full prevailing Blue Shield plus out-patient X-ray	$24.54	$58.86
2.	Percent of rate applicable to dental coverage (from special study)	1.03%	1.03%
3.	Monthly rate applicable to dental coverage under basic (Line 1 x Line 2)	0.253	0.606
4.	Rounded 1984 pure premium for basic dental	$ 0.25	$ 0.61

Exhibit C

1983 BLUE SHIELD OPTOMETRISTS

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1983 Incurred As Paid Thru 3-31-84 Single	Family	Unpaid Factors	Estimated Incurred Single	Family
Basic	$ 12,459.44	$ 20,337.34	1.026	$ 12,783.39	$ 20,866.11
X-Ray	3,346.00	3,832.20	1.026	3,433.00	3,931.84
Lab	124.45	208.00	1.026	127.69	213.41
Supplemental Accident	00.00	00.00	1.026	00.00	00.00
Miscellaneous*	6,145.18	267,806.36	1.026	6,304.95	274,769.33
Major Medical	58,850.58	80,820.26	1.610	94,749.43	130,120.62
First-Dollar Major Medical	23,783.17	94,530.49	1.250	29,728.96	118,163.11
National Joint Major Medical	4,974,58	7,832.20	1.487	7,397.20	11,646.48
Plan 65 and Disabled	10,186.47	00.00	1.022	10,410.57	00.00
Total	$119,869.87	$ 475,366.85		$ 164,935.19	$ 559,710.90

		Si	Fa
1.	1983 Contract Months	3,188,806	1,461,865
2.	1983 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)	$ 0.05	$ 0.38
3.	1984 Projected Pure Premium (trends = 1.086)	$ 0.05	$ 0.41

Exhibit D

1983 BLUE SHIELD PODIATRISTS

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1983 Incurred As Paid Thru 3-31-84 Single	Family	Unpaid Factors	Estimated Incurred Single	Family
Basic	$130,634.63	$ 160,615.37	1.026	$ 134,031.13	$ 164,791.37
X-Ray	22,048.12	26,749.42	1.026	22,621.37	27,444.90
Lab	1,155.65	1,623.38	1.026	1,185.70	1,665.59
Supplemental Accident	00.00	00.00	1.026	00.00	00.00
Miscellaneous*	35,593.22	100,345.85	1.026	36,518.64	102,954.84
Major Medical	6,779.28	9,432.40	1.610	10,914.64	15,186.16
Large First-Dollar Major Medical	42,101.80	105,663.05	1.250	52,627.25	132,078.81
National Joint Major Medical	1,263.80	5,664.96	1.487	1,879.27	8,423.80
Plan 65, MER, 'sabled	100,658.48	00.00	1.022	102,872.97	00.00
Total	$340,234.98	$ 410,094.43		$ 362,650.97	$ 452,545.47
				Si	Fa
1. 1983 Contract Months				3,188,806	1,461,865
2. 1983 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)				$ 0.11	$ 0.31
3. 1984 Projected Pure Premium (trends = 1.086)				$ 0.12	$ 0.34

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 1984 = $0.80

B. Blue Shield 1974 costs = $0.10; projected to 1985 = $0.34

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

Exhibit F

Mandated Coverages (Psychologists)

1.	Estimated 1984 cost to pay UCR benefits to psychologists versus statewide average under the basic psychiatric rider	$0.36	$0.56

Exhibit G

Mandated Coverages (Well Baby Care)

1.	Average estimated hospital charge for well baby care in 1984 at $119 per day for four days	$476.00
2.	Number of deliveries per contract month	0.0057
3.	Cost for well baby care in hospital (Line #2 X Line #1)	$2.70
4.	Average estimated physician's charge for well baby care projected to 1984	70.00
5.	Cost for well baby care for physician's services (0.0057 X $70.00)	0.40

Exhibit H

Mandated Coverages (Obstetrical Benefits on Single Contracts)

Cost for full coverage as filed with the Insurance Department:

		1984*
Blue Cross	=	$2.91
Blue Shield	=	$0.66

*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	$0.52	$2.22
Blue Shield	$0.29	$1.42

*(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)	$2.06	$3.95
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)	2.55	4.89
3.	Extension of days from 30 to 120 for Blue Cross (Line #2 - Line #1)	0.49	0.94
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%)	75.9%	76.0%
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 1984 filed rate	$1.87	$4.08
6.	Estimated 1984 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)	1.42	3.10
7.	Extension of days from 30 to 120 for Blue Shield (Line #5 - Line #6)	0.45	0.98
8.	Psychiatric charges above daily round for 30 days based on 1984 filed rate	0.59	1.33
9.	Psychiatric charges above daily round for 30 to 120 days based on 1984 filed rate	0.20	0.42

Exhibit K

Mandated Coverages (Outpatient Psychiatric Services)

		Single	Family
1.	Estimated 1984 additional cost to cover outpatient nervous and mental, chronic alcoholism and drug addiction at the same level as basic Blue Shield benefits	$3.75	$6.52

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 1984:

Single	=	$19.01
Family	=	$56.07

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 1984	$0.63	$1.58
2.	Rates approved and filed for in-patient physical therapy projected to 1984	0.09	0.24

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)

Too few physicians trained in Acupuncture to inpact 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 1984. Based on Home Health Agency experiments.	$0.05	$0.11

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	$1.28	$2.47
2.	Current rate filed with Insurance Department for full payment of charges for first 60 days only	0.28	0.55
3.	Additional rate needed to increase coverage of remaining 305 days to full	1.00	1.92
4.	Rate needed for full coverage for 365 days (Line #1 + #3)	2.28	4.39

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 1984	15,229
3.	Projected cost per service for Social Workers for 1984	$25.31
4.	Projected 1984 increase in cost for Social Workers services due to Mandate (Line #2 X Line #1 X Line #3)	$57,816.90

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	$30,100	$8,200
5.	Total charge to Blue Cross and Blue Shield for dialysis (Line #3 X Line #4)	$451,500	$123,000

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	$48.46	$36.69
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)	$121.15	$91.72
4.	Additional cost per contract month (Line #3 - Line #1)	$72.69	$55.03
5.	Estimated contract months for 1984	8,790	8,790
6.	Estimated 1984 additional costs (Line #5 X Line #4)	$638,945.00	$483,714.00

TOTAL NUMBER OF STATES WITH MANDATED COVERAGES

#11

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

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

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 COALITICN 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.

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

WHY SELF-INSURE?

1. ELIMINATE PREMIUM TAX

2. INCREASE CASH FLOW

3. AVOID MANDATED BENEFITS AND/OR REGULATION

#14

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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

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(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 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.''

MEDICAL BENEFITS

THE MEDICAL-ECONOMIC DIGEST

HOW INSURERS DETERMINE RATES

Business Insurance, December 23, 1985

"When insurers determine rate increases for health care coverage, one yardstick they use is the medical care component of the Consumer Price Index.

"For the first 10 months of this year, the CPI rose at an average annual rate of 3.8%, while the medical care component rose 6.8%, according to the Bureau of Labor Statistics, which compiles the CPI.

"However, inflation in the cost of medical care is not the only factor used to determine group insurance premiums, insurers say.

"The medical care component is 'one piece' of information used by Allstate Life Insurance Co. to determine rates, said Sherman Wolff, vp and actuary.

"'It's about 25%,' he added.

"In addition, Allstate relies on its research center in Menlo Park, Calif., to track health care trends.

"'The center looks at the length of hospital stays, utilization and about seven or eight other components,' Mr. Wolff said."

THE WORLD OF INSURANCE: WHAT WILL THE FUTURE BRING?

Lynn Etheredge, *Business and Health,* January/February 1986

"Recent developments demonstrate that private health insurance, so far, has not been able to meet many needs of government and business payers. If the private health insurance industry is to reverse current trends—and perhaps if it is to have much of a future at all—it will need to develop new market clout and value-added services for these major payers to assure quality health care and to restrain costs. Insurers who can do this may overcome the serious limitations that now threaten their demise.

"Insurance expertise in salesmanship, actuarial estimates, paying bills and portfolio investment are not the major skills needed to be successful in the emerging health care market."

"Large employers have become fairly rough on traditional insurance companies, particularly as they have discovered insurers' serious data limitations and inability to achieve realizable economies in a market that appears ideal for competitive purchasing of health care services. These dissatisfactions have been reflected in developments such as self-insurance, growth of HMOs and PPOs, and use of third party administrators (TPAs) for claims processing.

"Data reported by the Health Insurance Association of America (HIAA) demonstrates that an explosive growth has been underway in alternative financing arrangements. Administrative services only (ASOs) and minimum premium plans (MPPs) have expanded from 5 percent of private insurance before 1975 to 25 percent by 1980 and nearly 50 percent by 1984.

"The rapid move to self-insurance has been only one of the major inroads into the traditional health insurance marketplace. A second major challenge is coming from new enterprises that offer packages of insurance coupled with management structures that will contain costs. These new arrangements can be grouped into three major categories: HMOs; PPOs; and vertical integration-contracting arrangements.

"So far, most of the vertical integration-contracting developments have been occurring at the instigation of major, for-profit hospital chains, such as Hospital Corporation of America and American Medical International, which have purchased insurance companies to enable themselves to compete for insurance business.

"The traditional insurance method of paper claims processing, which provides most of the employment in the health insurance industry, is far behind the state of the art. Substantial economies are available in electronic claims submission, editing and processing, which can be realized by firms specializing in such services, but which most individual insurance companies do not have the volume to support.

"This data collection and dissemination competition may prove to be among the most severe for insurance companies. Once a terminal is in a physician's office or a hospital billing department is set up for on-line transmission to a central claims handling service bureau, establishing parallel systems will be difficult to justify. In turn, such data handling firms will be able to develop statistical profiles on health care charges and use patterns on a communitywide basis not available to individual insurance companies, and to efficiently transmit claims and information to insurance companies, PPOs, health data analysis contractors, utilization review firms

BILL WOULD ENCOURAGE HEALTH INSURANCE POOLS

By STEVEN BROSTOFF

WASHINGTON—Legislation to establish state health insurance pools for those with chronic health problems but no health insurance has been introduced in the United States Senate.

Sponsored by Sen. John Heinz (R.-Penn.), the legislation is a companion to a similar bill introduced into the House in March (See NU, April 6) by Rep. Barbara B. Kennelly (D.-Conn.). Called the "Health Insurance Availability Act of 1985," the legislation aims to provide protection to those individuals with pre-existing illnesses or impairments who are considered by insurers to be too risky for individual coverage.

The legislation is supported by Health Insurance Association of America, the leading trade association for health insurance companies. A representative of HIAA said the association supports the bill because it would apply to all health insurance plans, including Health Maintenance Organizations and self- insured businesses, and not just private insurance companies.

Under the proposed legislation, health insurance plans that fail to participate in a state health insurance pool would be subject to a special 10 percent excise tax. The individual states would have jurisdiction over the design and operation of the pools subject to several requirements.

These would include a limitation on the deductible of $2,500, a limitation on co-payment of 20 percent, a limitation on the out-of- pocket expense of the insured of $3,500 and a limitation on the premium to twice that of the average comparable individual health policy in the state.

Necessary legislation

In remarks to the Senate, Sen. Heinz said this legislation, which amends the tax code, is necessary because the Employee Retirement Income Security Act (ERISA) in effect prevents states from adopting legislation on their own which would require all health care plans to participate in pools.

Currently, health insurance pools exist in eight states, according to HIAA, including Connecticut, Rhode Island, Indiana, Minnesota, North Dakota, Wisconsin, Florida and Nebraska. However, Sen. Heinz said, because ERISA precludes states from regulating employee benefit plans, states cannot require that large self-insured employers participate in pools.

"Besides this being unfair competitively, this means that economically, the burden of any pool losses will be passed on to small businesses and individual policyholders while big businesses, now virtually all self-insured, are exempt," the senator said.

Sen. Heinz said that his legislation would eliminate this inequity and enable all states to create risk pools that would all insurers and self insureds on the same basis.

The senator added that he would have preferred amending ERISA itself to allow states greater flexibility to regulate self-insured employers. However, Sen. Heinz said, there is little political chance of enacting such legislation.

The coverage, he said, will not be cheap and it will not resolve the health care problems of the poor.

"It does, however, make available a group insurance plan for those middle-class Americans who want protection from catastrophic medical bills, who are willing and able to pay for it, but who cannot obtain coverage on the open market due to their health problems," he said. ◆

YOUR PRIMARY IMPACT WOULD BE ON

EMPLOYEE GROUPS

	# of Groups	# of Contracts	# of Subscribers
Less than 10 Contracts	11,990	29,121	70,069
10 - 24	1,160	18,694	45,726
25 - 99	903	44,853	105,904
TOTALS	14,053	92,668	221,699

AND, IN ADDITION . . . . . .

Farm	5,689	13,918
Non-Group	10,087	19,855
Plan 65	151,811	151,811
	167,587	185,584

(As of 7-1-85)

Following are some of the bills before the Kansas Legislature which would mandate increased costs on persons carrying traditional insurance coverage.

In most cases, they would not impact, or affect, persons in union-labor negotiated contracts, Federal Employees, Preferred Provider Organizations, HMO's, National Accounts, and Self Insured (almost half the large firms in the U.S. are self insured). They will basically impact small firms and individuals throughout the state as these people have no "escape mechanism".

HB 2167 - Sub SB 121 - Assigned Risk Pool - Has been a loser in every state.
HB 2170 - Mandate Alcoholism and Drug Abuse (over 6 million).
HB 2290 - Notice of Cancellation by Certified Mail.
HB 2362 - Medicare Supplement for Retirant in State Group.
HB 2302 - Continuation Conversion by Out-of-State Companies.
HB 2448 - Insurors Primary to Medicaid.
HB 2600 - Increase Premium Tax (increase of $3,500,000).
HB 2737 - Mandate Nervous (over $6,000,000) and Mental, Drug Abuse and Alcoholism.
HB 2812 - Emotionally Handicapped in Boarding Homes.
SCR 1621 - Insulin Pumps and Diabetic Self Management - 2.5 million for every 5% of diabetic population.

Federal Level

- Maternity Benefits - Mandated $8,500,000 Payment of Maternity for Single Contracts and Removal of Maternity Waiting Periods.
- Insurers Primary to Medicare on End Stage Renal Dialysis - $575,000.
- Working Aged Over 65 - Insurers Primary to Medicare - $1,122,000.
- Insurers Primary in VA Facilities - $395,000,000.
- Insurers Primary in Military Facilities.
- Continuation of Group Coverage for 18 Months for a Terminated Employee (Regardless of Reason for Termination) - Continuation for 30 Months for Widowed, Divorced and Dependents.
- Increase of Part B Premium and "Indexing" the Deductible.
- Catastrophic Coverage Under Medicare (a $12 to $13 monthly increase for Medicare Beneficiaries).
- Taxation of Blue Cross and Blue Shield - (over $6,000,000).
- Pre-Funding of Retirees Health Benefits.
- Increased Co-Insurance on Home Health (1% of Part A Deductible).

40-404. Additional deposit of securities; semiannual statements to be filed; penalties; how deposits kept. (a) Any life insurance company now or hereafter organized under the laws of this state shall deliver to the commissioner of insurance, to be deposited with the state treasurer in addition to the amount of capital required to be deposited, real estate, certificates of purchase and cash or securities of the kind or character in which the company shall be allowed to invest its funds, in an amount equal to the net reserve of all policies and annuity contracts in force in such company, the amount thereof to be determined by a valuation made, in accordance with the provisions of this code. Investments of the company in premium and policy loans, and the investment income due and accrued on investments which are not in default and are on deposit pursuant to this section, shall be considered a part of the legally required reserve deposit necessary to reinsure its outstanding risks, and may be retained by the company at its home office as a part of such reserve deposit, and such premium and policy loans shall not be subject to taxation. Within thirty (30) days after the thirtieth day of June and the thirty-first day of December in each year, each insurance company shall file with the commissioner of insurance under oath of its president or secretary a statement showing the dates and amounts of payments upon principal made during the preceding six (6) months on all mortgages on deposit ~~owned by said company;~~ and on the first day of January or within sixty (60) days thereafter in each year, each insurance company shall file a form prescribed by the commissioner of insurance setting forth the investment income due and accrued as of the previous December 31 which is included in such company's required reserve pursuant to this section. Willful failure to file any such statement as herein provided shall constitute a misdemeanor punishable by fine of not to exceed one

Attachment 3
House Insurance 2/13/86

AN ACT relating to insurance;

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 40-404a is hereby amended to read as follows: 40-404a. Any life insurance company owning real estate or which owns a certificate of purchase issued in any foreclosure proceeding on real estate in Kansas, may carry such real estate, or certificate, as a part of its legal reserve. Such real estate shall ~~first~~ be valued for deposit purposes ~~of~~ either the company's original cost, plus the cost of additional capital improvements, less accumulated depreciation, or at the value arrived at by the following appraisal process, at the company's option. Property that is to be appraised shall be appraised, at the expense of such company, ~~by three disinterested resident freeholders of the county where the land is situated, authorized~~ one appraiser selected by the company and approved by the commissioner of insurance to make such ~~appraisement, which appraisement~~ appraisal and such appraisal shall be final, except as hereinafter provided. ~~and~~ The value of ~~such~~ real estate for the purpose of such reserves shall ~~be the amount shown by such appraisal,~~ not ~~exceeding~~ exceed, in the case of real estate acquired by mortgage foreclosure or by direct transfer from the mortgagor, or in the case of certificates of purchase, the amount of unpaid balance of the face amount of the mortgage loan from which such real estate was acquired~~:~~. ~~Provided, That when any real estate, which is held pursuant to paragraph (3) or (4) of subsection (j) of K.S.A. 40-403e is subsequently sold by the insurance company upon a contract for deed or upon a deed with purchase money mortgage, and payment or payments in cash of not less than twenty percent of the purchase price have been made by the purchaser under a contract of sale providing for an annual payment of at least five percent of the principal amount of either the contract purchase price or of the purchase money mortgage, the commissioner of insurance, on his own initiative or at the request made to him by the company, shall have said real estate reappraised in the same manner as provided above, and title to said real estate subject to the contract for sale, or the purchase money mortgage may be deposited as a part of the legal reserve at the amount of the unpaid balance due on the contract, not exceeding eighty percent of the appraised value of the real estate: Provided, however, That~~ At no time shall the total amount of such real estate and/or certificate of purchase so deposited exceed fifty percent of the total amount of the gross reserves on all outstanding policies of the company making such deposit, and deposits not to exceed ten percent of such gross reserve may be on real estate and/or certificates of purchase on real estate outside of Kansas.

The commissioner of insurance shall have the right to reject at any time and return any property upon which taxes are delinquent, or fire insurance premiums unpaid. Deeds to such real estate and assignments of such certificates so deposited shall be executed by such company, conveying or assigning the title thereto to the then commissioner of insurance of the state of Kansas and his successors in office, in trust for the use and benefit of such company, and such deeds and such assignments shall be recorded in the office of the register of deeds of the county in which such real estate is situated and shall be deposited with the state treasurer as proper security under and according to the provisions of the act. Whenever the redemption period on any certificate assigned to the commissioner shall have expired the sheriff of the county in which such land is situated shall issue a deed to said property to the commissioner of insurance and his successors in office in trust for the use and benefit of such company, and such deed shall be recorded and held in lieu of such certificate. When any company desires to withdraw such real estate from its reserves, the then commissioner of insurance shall, upon request, execute deeds to such person or persons, company or corporation as such insurance company shall direct. ~~Said appraisers shall each be allowed not to exceed the sum of twenty five dollars ($25) per day in full for all services rendered except that~~ The commissioner of insurance may appraise real estate outside of Kansas at the expense of the company in such manner as he may determine, and may ~~reappraise all real estate once in every five (5) years.~~ require any company to appraise or reappraise any real estate upon reasonable request and 60 days written notice.

Sec. 2. K.S.A. 40-404a is hereby repealed.