Approved April 2, 1986
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Sen. Neil H. Arasmith
Chairperson at

9:00 a.m./~~p.m.~~ on April 1, 1986 in room 529-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Legislative Research
Myrta Anderson, Legislative Research
Bruce Kinzie, Revisor of Statutes

Conferees appearing before the committee:

Steve Robertson, Health Insurance Association of America
Jack Roberts, Blue Cross/Blue Shield
Tom Miller, V.P., Internal Affairs, Blue Cross/Blue Shield
Richard Harmon, Kansas Life Association
David Litwin, Kansas Chamber of Commerce and Industry
Ron Gaches, Boeing Military Airplane Company
John Houlehan, Mid American Bank in Roeland Park
Pete McGill, Kansas Independent Bankers

The mintues of March 31 were approved.

The hearing for opponents of HB 2737 dealing with insurance coverage for alcohol, drug abuse or nervous or mental conditions began with the testimony of Steve Robertson of Health Insurance Association of America. (See Attachment I.)

Jack Roberts, Blue Cross/Blue Shield, testified that he opposes mandated benefits which are a part of the health care cost problem. He feels there will probably be another health care cost crisis in the next few years, and this is part of it. Also, mandated coverage removes the choice for the public and negates third party negotiation. Blue Cross has offered riders on many things, and the dental and outpatient riders have not been accepted well. He passed out two exhibits which show who pays for mandated insurance coverage. (See Attachments II and III.) He said one mandate can undo a tremendous amount of rate reduction such as Blue Cross has done recently. He concluded that the current law is good, and individuals should be able to make their own decision on health care requirements.

Tom Miller, Vice President of Internal Affairs for Blue Cross/Blue Shield, testified further speaking as a corporate actuary. He said the bill would cause adverse selection. Those that have a known need will purchase insurance offered on an optional basis. The offering of coverage on an individual optional basis will probably cause rates to escalate, and he asked that this provision be removed from the bill. He distributed copies of cost information. (See Attachment IV.)

Richard Harmon, Kansas Life Association, opposes the bill for the following reasons: (1) The cost factor--It will create higher premiums (approximately 2½% increase), (2) It will encourage groups to self-insure which takes them outside regulatory control, and (3) It restricts freedom of choice.

David Litwin, Kansas Chamber of Commerce and Industry, testified next. (See Attachment V.) He also stated that subsection (e) is philosophically on the right track, but it does not go far enough.

Ron Gaches, Boeing Military Airplane Company, followed. He informed the committee that Boeing did not request subsection (e) as many have thought. It does put Boeing in the curious position of having mandated coverage for salaried employees but not for hourly paid employees. Mr. Gaches said that employers generally oppose further mandated insurance coverage not only because of the cost increase for coverage but also because of the cost of the loss of freedom. It would also mean increased mandated coverage in the future. Mandated coverage increases the demand for that service, and this causes the

cost of that service to increase.

At this time, Sen. Burke distributed copies of a statement by Sherry Wood of the Drug and Alcohol Council of Johnson County in support of the bill. (See Attachment VI.) Also, the chairman had distributed copies of a letter from Robert Eisler, Jr., of PrimeHealth. (See Attachment VII.) This concluded the hearing on HB 2737.

Attention was turned to HB 3097 authorizing trust services at detached bank facilities. John Houlehan, Mid American Bank in Roeland Park, testified in support of the bill. (See Attachment VIII.) As part of his testimony, he distributed copies of information showing that savings and loans and credit unions have an unfair advantage over banks in Johnson County. (See Attachment IX.)

The chairman asked Mr. Houlehan if he has any objection to the original bill, and he answered that he does not. Sen. Werts asked if he would object to the contiguous counties language being limited, and he replied that any step towards branching is good.

Pete McGill, Kansas Independent Bankers, testified in opposition to the House floor amendment. (See Attachment X.) Upon conclusion of Mr. McGill's testimony, the chairman noted that there has been little opposition to the original bill. This concluded the hearing on HB 3097.

The meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
4/1/86	John Houlehan	4700 W. 50th Ten. L. M. Ks.	Mid American Bank & Trust Co
"	Jim Allen	Topeka	KBA
"	Chip Wheelen	Topeka	KIBA
"	Pete McGill	"	KIBA
"	Sue Anderson	Carbondale	KIBA
"	Ron Gaches	Wichita	BMAC
"	Paul M. Klotz	Topeka	Assoc. of CMHCs of Ks.
"	BRYCE MILLER	TOPEKA	MHAK
"	Thomas Mills	"	BC & BS
"	JACK ROBERTS	"	BC-BS
"	Steve Robertson	1350 E. Touhy Ave Des Plaines	HIAA
"	Richard Harmon	Topeka	KS Life Assn.
"	Elizabeth A. Taylor		Ks A/D Prog Dir v Counselor
"	Jim McHenry	Topeka	SRS/Alcohol + Drug Abuse Serv
"	Jim McBride	Topeka	observer
"	Lori Class	"	United Way
"	ALLYN D. LOCKNER	"	SRS
"	Linda McGill	"	KIBA
"	Jack Peterson	"	Ks Assn Sch Psychologists
"	Ron Todd	"	Ks. Dept. of Insurance

Statement to the Kansas Senate Committee
On Financial Institutions and Insurance
From the Health Insurance Association of America
In opposition to House Bill 2737

The Health Insurance Association of America (HIAA) represents approximately 335 insurance companies responsible for over 85% of the health insurance written by health insurance companies in the United States.

The HIAA opposes the adoption of House Bill 2737 for two reasons. First, the HIAA favors the freedom of contract that allows insurance purchasers to seek benefits for the coverage they choose to purchase and carriers offer. Second, the legislation unfairly treats purchasers of health care benefits from insurance companies by requiring certain health benefits be included in insurance policies that would not be required if the purchaser would utilize a self-funding mechanism.

The purchaser of health care benefits does not have unlimited funds to purchase benefits. Each mandated benefit causes an increase in the premium an individual must pay in order to have the coverage included in their health insurance policy. For example, if the present requirements under K.S.A. 40-2,105 would be mandated our companies estimate that health insurance premiums on group policies in the state of Kansas would rise by a minimum of 2-1/2%. In 1985, the HIAA prepared an extensive report concerning mandated benefits and presented the report to the Maryland House of Delegates Committee on Economic Matters. Part of the report gave cost estimates of various mandated benefits. Please see Exhibit 1. Also included as Exhibit 2 is a state by state analysis, as of July 1985, of Alcoholism, Mental Illness and Drug Addiction coverage.

If House Bill 2737 would become law, it is estimated that it would affect at most 60% of the residents in the state of Kansas. The remaining 40% would not be subject to the law because they utilize a self-funding mechanism. Since 1975, it is estimated that the amount of the self-insureds, on a national basis, has increased from 13% of the total population to 40%. This figure is expected to continue to rise. As a result, traditional health insurance has seen its market shrink. This shrinking population base not only affects the amount of insurance sales, but it also decreases the amount of premium tax that a state receives from insurance companies. Please see Exhibit 3. The state of Nebrasaka has recently sent to the Governor Legislative Bill 895 which in effect has recognized the self-insured issue. Legislative Bill 895, in essence, prohibits any law that mandates a benefit in health insurance policies from being applicable to those health insurance policies until the federal government removes exemptions from self-insured ERISA exempt plans. Please see Exhibit 4.

The HIAA opposes House Bill 2737 and urges this committee not pass it out favorably.

Respectfully submitted,

Stephen W Robertson

Stephen W. Robertson
Counsel
Health Insurance Association of America

SWR/cp

S. FII 4/1/86
Attachment I

Exhibit 1

1.

CHAIRMAN RUMMAGE REQUESTED A DETERMINATION OF THE PORTION OF THE MONTHLY MARYLAND INSURANCE PREMIUM ALLOCABLE TO MANDATED BENEFITS FOR BOTH GROUPS AND INDIVIDUALS.

For purposes of this study, the minimum benefit mandated by law was priced by an actuarial subcommittee of the Task Force, using empirical methods similar to those used in the operation of the insurance business. It should also be stressed that these mandated benefits/providers were priced without regard to whether there might be cost reductions elsewhere in the plan. The Task Force recognizes that some of these mandated benefits/providers, such as home health care and hospice care, may result in reducing the costs attributable to other plan benefits. The Task Force is unaware of any convincing demonstration of the net effect on aggregate plan costs. Therefore, it was unable to weigh the conflicting predictions as to cost reductions and believes this is best left to the emergence of actual experience.

Table 1 shows the monthly insurance premium split between existing Maryland mandated benefits and the unmandated balance of benefits for a typical group plan. Table 2 shows the apportionment of this monthly premium to each existing mandated benefit within Maryland. The column labeled "Employee Premium" represents the premium for an employee without dependents. The column labeled "Family Premium" represents the combined premium for an employee with one or more dependents.

The following assumptions were used in determining the premium amounts shown in Tables 1 and 2:

(1) Comprehensive group major medical plan with a $100 deductible, 80% insurance for the first $5,000 of covered expenses and then 100% to a $1,000,000 lifetime maximum. (See Appendix C for a more detailed description of the plan.)

(2) Group is located in average cost area for Maryland (Baltimore, for example, is a high cost area). Actual premiums charged to groups located in Maryland may differ significantly from the average premium amount shown in Tables 1 and 2. These differences in premium rates could be due to many factors, such as plan of insurance, geographic location of group, demographics of group, insurance company quoting rate, etc.

(3) Census of illustrative group is listed in Appendix D.

(4) Where a minimum benefit has been mandated, such as for the treatment of nervous and mental illnesses, the plan described in Appendix C provides the minimum coverage mandated.

(5) Premium amounts represent the consensus input from several commercial carriers.

If any of these assumptions is changed, the amounts in Table 1 and Table 2 are likely to change.

TABLE 1

Benefit Category	Employee Premium	Family Premium
Mandated	$11.05	$ 46.10
Non-mandated	83.95	223.90
Total	$95.00	$270.00
% of Mandated to Total	12%	17%

TABLE 2

Mandated Coverages	Employee Premium	Family Premium
Nervous and mental[4/]	$6.19	$16.17
Alcoholism	1.68	3.86
Drug abuse	.67	1.54
Psychiatric day treatment	1.00	2.58
Cleft lip and palate	*	*
Blood, plasma	*	*
Maternity and newborn[5/]	2.58	23.69
In vitro fertilization	*	.60
Mandated Providers		
Chiropractor	1.40	3.52
Nurse anesthetist	*	*
Nurse midwife	*	*
Nurse practitioner	*	*
Optometrist	*	*
Podiatrist	.27	.68
Psychologist	.86	2.18
Social worker	.18	.46
Mandated Settings		
Home health care	*	*
Hospice care	*	*

*Less than $.10 for employee premium and less than $.27 for family premium.

[4/] Part or all of the premium for alcoholism, drug abuse, psychiatric day treatment, psychologists and social workers is included in the premium for nervous and mental. For this reason the sum of the amounts in Table 2 is greater than the amount for mandated benefits shown in Table 1.

[5/] Federal law mandates maternity benefits for employer groups larger than 15 lives. Over 90% of the premium cost of maternity and newborn care shown in Table 2 is attributable to federal law.

Since many of the mandated items represent a very small component of the total premium, most companies do not have factors/prices for these items nor do they maintain or capture claims data related to these items. Unless an optional item represents at least 1% to 2% of expected claims, most companies will not develop a separate premium charge for it. Consequently, many of the amounts shown in Table 2 were developed specially for this project without supporting claims statistics.

Because group insurance is primarily experience rated rather than rated on a purely manual rate basis, such as is done in individual insurance, pricing factors are developed and maintained only for those plan variables having a material cost impact, such as different deductible amounts. For a further description of the pricing practices regarding mandated items, see Section 4.

It should be pointed out that most group claims systems do not capture and maintain detailed claims data, such as type of provider, because this data is not necessary in order to pay a claim correctly. In addition, actuaries do not need detailed claims data on small items to fulfill their pricing responsibilities nor do group policyholders request such information. Detailed claims data on small items simply has been of little or no value to an insurer. Nevertheless, these items can be significant when aggregated.

However, as the cost of medical care has continued to escalate in recent years, many group policyholders have been requesting more detailed claims information. They want to learn how their claims dollars are being spent in hopes of being able to better control their health care costs. To respond to these requests, insurance carriers are having to redesign portions of their claims systems to capture the requested data in addition to the basic required claims data. As a result of all this activity, it is expected that insurers will have more detailed claims information available in the future, but it still may not provide all the information needed to price each mandated benefit.

Although Table 2 is for a group insurance plan, the proportion of the total premium shown for some of the mandated items in Table 2 would be similar, in general, for an individual major medical policy. The absolute dollar amounts, however, can be expected to be higher for an individual plan because premium rates generally reflect higher expenses for individual policies. The proportion of the premium represented by some mandated items, however, may differ considerably for an

individual policy from those shown in Table 2, depending on the age and sex of the individual insured. In addition, the proportion of the premium for certain of the mandated items would be much greater under an individual policy than is shown in Table 2 for a group policy because adverse selection is a greater problem under individual policies. (See Section 2 for further discussion of adverse selection.)

There are several reasons why cost tables for individual plans, similar to Tables 1 and 2 for group, are not included in the response. First, companies do not offer as many options or variations in their individual policies as they do in their group policies. Second, companies periodically adjust the rate for various geographic areas in light of actual emerging claims experience. The existence of this geographic rating factor in premium structures makes it unnecessary to isolate the claims cost for each mandated benefit. Consequently, most companies do not need separate rates for these items in Maryland or in any other states. Third, and probably most important, the claims statistics captured for individual policies by most companies are considerably less detailed than those captured for group policies. Less detail in the claims statistics for individual policies is due primarily to the lack of usefulness of such detailed data, compared to the cost of collecting it, in pricing individual policies. In addition, it is not necessary to report claims data to individual policyholders as is true with many large group policyholders.

APPENDIX C

BENEFIT PLAN DESCRIPTION

I. Mandated coverages

A. Nervous and mental

Covers at 50% coinsurance expenses arising from acute mental illnesses and emotional disorders which are subject to significant improvement through short-term therapy up to a maximum of 30 inpatient days at a hospital in a calendar year.

B. Alcohol rehabilitation

Covers expenses for the treatment of alcoholism in a calendar year:

(1) Up to 7 days for emergency care or detoxification in an acute general hospital or a nonhospital detoxification facility licensed by the Department of Health and Mental Hygiene;

(2) Up to 30 days for care in a Type C or D facility as specified in the law; and

(3) Up to 30 outpatient visits at a certified alcoholism treatment facility up to a maximum of $1,000.

C. Drug abuse

Covers expenses for the treatment of drug abuse:

(1) Up to 21 days as an inpatient in a hospital or residential treatment facility; and

(2) Up to $1,000 in any 12-month period in an out-patient treatment program.

D. Psychiatric day care

Covers expenses for psychiatric care for up to 30 partial hospitalization treatment days in any 12-month period.

ALABAMA

Group/blanket hospital or medical expense and hospital/medical service contracts covering mental health services shall pay for services of psychiatrist or psychologist. Reimbursement to be made for outpatient and inpatient services if requested by attending physician. (Note: does not mandate or require inclusion of mental health services; not to be construed to expand scope or nature of benefits when such services included in contract). §27-1-18 (5/4/82)

ALASKA

NONE

ARIZONA

If contract provides coverage for alcoholism, drug abuse or psychiatric services, reimbursement shall be made whether covered service rendered in general hospital or psychiatric special hospital. Applies to contracts delivered on or after 1/1/80 and to existing group contracts thereafter on renewal, anniversary date or expiration of collective bargaining agreement. §§20-841; 20-934; 20-1057; 20-1376; 20-1406 (1/1/80)

ARKANSAS

Individual/group contracts providing payment of any health care services provided by hospitals or related facilities shall cover on equal basis services provided by licensed outpatient psychiatric center. Also applies to out-of-state group contracts. §66-3212(11) (120 days after 7/20/79)

Group/subscriber contracts providing hospital or medical benefits to state residents must offer coverage for mental illness unless refused in writing. Copayments may not exceed 20% for inpatient, partial hospitalization, or outpatient care. Benefit limit not less than $7,500 per year. §§66-3716 & 3717 (3/3/83; 8/1/85)

CALIFORNIA

Group hospital, medical and surgical contracts must offer to policyholder such benefits as may be agreed upon. If agreed-upon terms of mental health coverage include coverage for services provided in a general or psychiatric acute care hospital, coverage shall extend to care provided by a psychiatric health facility, except that if the policy restricts the choice of providers, such restrictions shall apply. Also provides that coverage may include community residential treatment services. Applies to group disability insurers, nonprofit hospital service plans, and self-funded employee welfare benefit plans; and imposes similar obligations on health care service plans. §10125 (1/1/74; 1/1/85)

CALIFORNIA (continued)

Must communicate to prospective group policyholders as to the availability of outpatient coverage for the treatment of mental or nervous disorders. §10125 (1/1/84)

Out-of-state contracts recognizing psychologists in state of issue may not exclude such services rendered by California psychologists not licensed in state of issue. §§10176.5; 10177.5; 11512.2 (1/1/82)

Similar requirement for clinical social workers, mental health nurses, marriage, family and child counselors. §10176.7 (1/1/84; amd. 1/1/85)

COLORADO

Group hospital and medical expense contracts must include as to basic contracts 45 days inpatient and 90 days "partial" on a "2 for 1 day" basis; as to major medical contracts, same as basic with up to 50% coinsurance (also see Alcoholism). §10-8-116 (1/1/76)

Group and nonprofit hospital and health service corporations' policies providing hospitalization or medical benefits must provide benefits for conditions arising from mental illness at least equal to following: major medical - outpatient services furnished by a comprehensive health care service corporation, hospital, or community mental health center or other mental health clinics approved by Department of Institutions to furnish mental health services or furnished by or under supervision of licensed physician or psychologist. Services shall be under direct supervision of physician or psychologist and patient records shall show that attending physician or psychologist either saw the patient or had a written summary of consultations or a personal consultation with the therapist at least once every 90 days. Insurer may require provider to furnish written certification that such services were provided under supervision of licensed physician or psychologist. Reg. 83-2 (2/1/84)

CONNECTICUT

All group contracts must provide up to 60 days inpatient; major medical contracts shall provide benefits (outpatient) after applicable deductible, at 50% rate during any calendar year, up to $1,000. §38-174d (5/28/75)

Insurer must cover partial hospitalization for mental illness on exchange basis with covered inpatient days; insurers to offer additional outpatient for mental illness treatment. §38-174d (10/1/82)

In case of benefits payable for service of licensed physician practicing as psychiatrist or licensed psychologist, benefits for outpatient services will be payable if rendered: (1) in nonprofit community mental health center as defined by Department of Mental Health or in nonprofit licensed adult psychiatric clinic operated by accredited hospital; (2) under supervision of psychiatrist or licensed psychologist; and (3) within scope of license issued to center or clinic by Department of Health Services. §38-174d(g) (10/1/83)

DELAWARE

NONE

DISTRICT OF COLUMBIA

NONE

FLORIDA

Group, HMO and hospital/medical service corporations shall make available benefits same as other illness except: inpatient may be limited to not less than 30 days per benefit year, any excess need not be same as other illness; if offering outpatient benefits, coinsurance need not be the same, maximum yearly benefit may be limited to $1,000 for consultations and excess dollar amounts need not be same as applied to physical illness generally. If alternative inpatient-outpatient or partial hospitalization benefits are selected, such benefits shall not be less than the level of benefits specified in subsection (2) of the section; benefits for mental health professionals may be limited to licensed professionals. §627.668 (10/1/83)

GEORGIA

Contracts providing hospital care which do not cover mental illness must contain statement in bold face type to this effect on contract and any identification card. §§33-29-5 & 6 (7/1/70)

Major medical contracts issued, delivered or renewed after 1/1/82 must make available to insured, covered spouse and dependents treatment of mental disorders same as other physical illness. Insurers may limit coverage per policy year as follows: Individual: inpatient-30 days; outpatient-48 visits; Group: inpatient-60 days; outpatient-50 visits. §33-24-28.1(b) (10/1/81; 7/1/84)

HAWAII

NONE

IDAHO

NONE

ILLINOIS

Group contracts must offer benefits with annual maximum of at least lesser of $10,000 or 25% of lifetime policy maximum and coinsurance of 50% or less. §370c (7/1/77)

INDIANA

NONE

IOWA

NONE

KANSAS

Unless refused in writing, group insurers must provide coverage for treatment of alcoholism, drug abuse or nervous or mental conditions for no less than 30 days per year in licensed hospital or facility and outpatient benefits limited to not less than 100% of first $100 and 80% of next $500 in any year. §40-2,105 (7/1/78)

KENTUCKY

NONE

LOUISIANA

Group/blanket/franchise/self-insured must offer mental and nervous disorder coverage on same basis as other conditions. Such coverage to include services of licensed psychologist and certified social worker when in collaboration and consultation with physician assuming full patient responsibility. §22:669 (9/13/81)

MAINE

Group, blanket and nonprofit hospital or medical service corporations shall provide minimum annual benefits for mental illness or nervous conditions as follows: inpatient 30 days with coinsurance of 80% or level of benefits provided for any other illness; $1,000 for any combination of outpatient and/or day treatment care with coinsurance of 50% of UCR charges; $100 deductible; maximum lifetime benefit of $25,000, except that policy total maximum benefit need not be exceeded. Persons covered under both basic and major medical policies may not "stack" benefits of both policies. Policy may limit or exclude benefits to extent coverage would duplicate and be secondary to Medicare but must cover difference between Medicare and minimum required benefits. 24-A§2843 (9/23/83); Rule C. 330 (6/1/84)

MARYLAND

Individual/group/nonprofit contracts must cover expenses for treatment of acute mental illness and emotional disorders which are subject to significant improvement through short-term therapy. Inpatient: 30 days per calendar year or benefit period; major medical: not less than 50% of benefits provided for other types of illness. *Extraterritorial. 48A§§354D; 470E(a); 477E(a) (7/1/73; 7/1/81*)

Group/nonprofit contracts must offer option of benefits for psychiatric care through partial hospitalization. Minimum of 30 partial hospitalization days during any consecutive 12-month period. 48A§§354J; 477M (1/1/77)

MASSACHUSETTS

Individual/group/blanket/employee welfare benefit plans must include 60 days inpatient in mental hospital; general hospital same benefits as for other illness; outpatient up to $500 over 12-month period. C. 175 §47B (6/1/76)

MICHIGAN

NONE

MINNESOTA

Group contracts covering at least 100 state residents or groups comprised of more than 90% state residents which provide mental illness benefits must provide 80% of first $750 outpatient expense by hospital, community mental health center or approved mental health clinic, or consulting psychologist or psychiatrist. §62A.152 (8/1/75; 8/1/81)

Group/HMOs/health service plans shall include benefits, on same basis as other benefits, for treatment of emotionally handicapped children in residential treatment facility licensed by Commissioner of Public Welfare. §62A.151 (7/1/75)

Group policies providing benefits for mental or nervous disorders in a hospital must provide direct reimbursement for those services when performed by licensed consulting psychologist to extent services are within scope of such license. Carriers in administering claims may require order of physician requesting such services. §62A.152 (7/1/83)

MISSISSIPPI

NONE

MISSOURI

Insurers/health service corporations/HMOs shall offer coverage of psychiatric services for recognized mental illness as follows: (1) if providing inpatient benefits, same as other illness; may be limited to 30 days in benefit period; (2) if providing outpatient benefits, treatment in psychiatric residential treatment center on inpatient or outpatient basis when prescribed by physician specializing in treatment of mental illness. Not less than 50% reasonable charges to maximum of $1500 in benefit period. Shall offer 50% reasonable charge for 20 psychotherapy services rendered by physician specializing in treatment or mental illness or psychologist unless rejected by policyholder. Frequency of sessions may be limited but benefit shall be available for at least 1 session in any 7 consecutive days. §376.381 (8/13/80)

MONTANA

Insurers and health service corporations' hospital and medical expense contracts must make available benefits for care and treatment of mental illness, alcoholism and drug addiction on same basis as other benefits, except inpatient benefits may be limited to 30 days per year; outpatient to $1,000 per benefit period; and maximum lifetime benefits to $10,000 or 25% of lifetime contract limit whichever is less. Does not apply to blanket, shqrterm travel, accident only, limited or specified disease, individual conversion, or Medicare Supplement contracts. §§33-22-701 through 704 (1/1/82)

On effective date, amends above to require group/health service corporations' hospital and medical expense contracts to provide minimum aggregate benefit levels. Treatment plans approved by "chemical dependence counselors" (i.e., can't require physician approval). §33-22-701 (12/31/84)

NEBRASKA

NONE

NEVADA

NONE

NEW HAMPSHIRE

Minimum group benefits: (1) basic hospital expense contracts, same benefits as for any other illness; (2) basic medical expense contracts, same benefits as for physicians for other illnesses--outpatient same as any other illness, except may be limited to 15 hours treatment over 12 months; (3) major medical contracts, deductible and coinsurance at least same as for any other illness with 12-month maximum of not less than $3,000 per covered individual. §415:18-a (amd. 6/4/76)

Group/blanket policies must provide coverage for treatment at psychiatric residential program approved by Division of Mental Health and Developmental Services. §415:18-a.III.b (8/22/83)

NEW JERSEY

NONE

NEW MEXICO

NONE

NEW YORK

Must make available on request: (1) inpatient, not less than 30 days per calendar year; (2) outpatient may be limited to $700 per calendar year. New §§3221(k)(5); 4303 [C. 894; §162.16] (1/1/78)

NORTH CAROLINA

NONE

NORTH DAKOTA

Must provide 70 days inpatient, 140 days outpatient for group/blanket/franchise over 50 lives and who cover 70% or more of group. §26-39-01 (7/1/75); Bul. 30

OHIO

Group medical expense contracts, other than accident only or specified disease, that provide benefits for mental or emotional disorders shall provide benefits on outpatient basis equal to $550 in any calendar year or 12-month period. §3923.28 (1/1/79; 1/1/83)

OKLAHOMA

NONE

OREGON

Mandated benefits in group policies for alcoholism, chemical dependency and mental illness. Benefits must be provided whether performed in health or residential facilities, or on outpatient basis, or by physicians, psychologists, nurse practitioners, or clinical social workers. May be subject to provisions of policy applicable to other benefits, including coinsurance and deductibles, except that coinsurance and deductibles for treatment in health or residential facilities may not be greater than for hospitalization, and for outpatient treatment, may not be greater than for other outpatient treatment.

OREGON (continued)

Total benefit dollar amounts may be limited depending on whether services are for alcoholism, chemical dependency, mental illness, or combination thereof, or whether provided in health or residential facilities, or outpatient basis, or combination thereof. Insurers allowed option of implementing certain "cost containment" features. §§743.557 & .558 (1/1/84; sunsets 7/1/87)

Individual/group contracts may not exclude benefits for services rendered in state approved community mental health programs. §743.116 (7/21/81)

PENNSYLVANIA

NONE

RHODE ISLAND

NONE

SOUTH CAROLINA

NONE

SOUTH DAKOTA

NONE

TENNESSEE

Unless specifically excluded, individual, franchise, blanket or group contracts must provide benefits for psychiatric disorders, mental or nervous conditions, alcoholism, drug dependence or medical complications of mental illness or mental retardation. Benefits not defined but must be provided for services rendered in health facility licensed in state as hospital accredited by Joint Commission on Accreditation of Hospitals, or facility owned or operated by state which is especially intended for diagnosis, care and treatment of psychiatric, mental or nervous disorders, or licensed and accredited residential treatment facility. §§56-7-1003 (7/1/74); 56-7-1004 (7/1/81)

Group hospital, medical or major medical contracts shall make available outpatient benefits in community mental health centers which shall include minimum of 30 outpatient visits per year and deductibles and coinsurance not less favorable than illness generally. Benefits shall be part of contract unless policyholder rejects in writing. If contract provides inpatient benefits, shall include community mental health centers with inpatient care facilities. §§56-7-1003 & 1004 (7/1/80)

TENNESSEE (continued)

When optional benefits offered under §56-7-1003 are provided for mental, emotional or nervous disorders, alcoholism, drug dependence or medical complication of mental illness or mental retardation, and treatment is received at community mental health center, such benefits provided when services are rendered by a physician shall also be provided when rendered by a member of the clinical staff of the community mental health center provided the center has in effect a plan for quality assurance approved by the Department of Mental Health, and such treatment is supervised by licensed physician or clinical psychologist. §56-7-1003(b) (6/5/84)

TEXAS

Group, HMOs, service plan contractors providing inpatient coverage for mental or emotional illness or disorders shall provide coverage for treatment under direction of M.D. or D.O. in psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from inpatient programs, subject to same durational limits, deductibles and coinsurance factors. Each full day of treatment equal to half-day inpatient treatment. Policyholder has right to reject coverage for treatment of mental or emotional illness or disorder or may select alternative level of benefits if offered or negotiated. Alternative level of benefits must provide benefits for treatment in such facilities equal to at least one-half that provided for hospital treatment. (Note: policies delivered to group policyholders before effective date governed by law in effect at that time and "continued in effect for that purpose.") Art. 3.70-2(F) (1/1/83)

UTAH

NONE

VERMONT

Group contracts must provide option of "45 day equivalents of active care" per contract or calendar year; outpatient at 100% for first 5 visits, 80% thereafter, up to $500 per policy or calendar year. 8§4089 (10/1/76)

VIRGINIA

Individual/group contracts must provide same benefits as for other illness, up to 30 days treatment per year. Group contracts must offer outpatient same as other benefits, but may limit to $1,000 per benefit period at 50% coinsurance. §38.1-348.7 (11/1/77)

WASHINGTON

Group/HMOs/Blues must offer optional supplemental coverage for mental health treatment rendered by licensed physician, psychologist, or community mental health agency at usual and customary rates. Coverage may be subject to contract provisions with respect to reasonable deductibles and copayments. Coverage may be waived for all covered persons if contract holder so states in advance in writing. §48.21.240 (7/1/83); Bul. 83-3 (7/22/83); Bul. 83-5 (11/1/83); Bul. 84-4 (7/2/84)

WEST VIRGINIA

Individual/group contracts shall provide, unless rejected by policyholder, at least 45 days inpatient in mental hospital, outpatient benefits at 50% coinsurance up to $500 up to 50 visits per year and services in comprehensive health service organization; community mental health center; by psychiatrist or psychologist. Inpatient in regular hospital--same as other illness. §§33-15-4a; 33-16-3a (7/4/77)

WISCONSIN

Group contracts must include at least 30 days inpatient coverage and up to first $500 of outpatient service per calendar year. Treatment in community-based residential facilities included. §§632.89 & 632.89(2)(b)2 (9/1/74; 7/13/83)

WYOMING

NONE

PUERTO RICO

NONE

ALABAMA

NONE

ALASKA

NONE

ARIZONA

If contract provides coverage for alcoholism, drug abuse or psychiatric services, reimbursement shall be made whether covered service rendered in general hospital or psychiatric special hospital. Applies to contracts delivered on or after 1/1/80 and to existing group contracts thereafter on renewal, anniversary date or expiration of collective bargaining agreement. §§20-841; 20-934; 20-1057; 20-1376; 20-1406 (1/1/80)

ARKANSAS

NONE

CALIFORNIA

NONE

COLORADO

NONE

CONNECTICUT

Individual and group hospital or medical expense contracts must provide at least 30 days inpatient and up to $500 outpatient for accidental ingestion of a controlled drug. §38-174i (7/1/75)

DELAWARE

NONE

DISTRICT OF COLUMBIA

NONE

FLORIDA

Drugs, narcotics, hallucinogens are permitted exclusions. Rule C. 4-37.05 (1/1/75); UPPL §627.629

GEORGIA

NONE

HAWAII

NONE

IDAHO

NONE

ILLINOIS

NONE

INDIANA

NONE

IOWA

NONE

KANSAS

Unless refused in writing, group insurers must provide coverage for treatment of alcoholism, drug abuse or nervous or mental conditions for no less than 30 days per year in licensed hospital or facility and outpatient benefits limited to not less than 100% of first $100 and 80% of next $500 in any year. §40-2,105 (7/1/78)

KENTUCKY

NONE

LOUISIANA

Group, blanket or franchise contracts to include as option coverage for treatment of alcoholism and drug abuse rendered or prescribed by physician licensed in state, received in hospital or any other public or private facility including freestanding, nonhospital based treatment and rehabilitation programs. Contracts in force 10/1/82 shall provide such option. §22:215.5 (9/7/79; 9/1/82)

MAINE

Group, blanket and nonprofit hospital or medical service corporations shall provide annual benefits for alcoholism and drug dependency to include: residential treatment--30 days except need not exceed total policy inpatient days, coinsurance lesser of 90% or level provided for any other illness, maximum lifetime benefit of 60 days; outpatient--$1,000, coinsurance lesser of 80% or level provided for any other illness, $100 deductible, lifetime maximum $25,000 except need not exceed policy total maximum. Persons covered under both basic and major medical policies may not "stack" benefits of both policies. Policy may limit or exclude benefits to extent coverage would duplicate and be secondary to Medicare but must cover difference between Medicare and minimum required benefits. 24-A§2842 (9/23/83); Rule C. 320 (6/1/84)

MARYLAND

Insurer must offer drug abuse treatment coverage to group policyholders where new or extended contracts cover 25 or more lives. Coverage to include 21 days inpatient treatment in licensed facility. Major medical policies' coverage of outpatient treatment to extent of 80% of cost but not required to exceed $1,000 in any 12-month period. 48A§§354M; 477Q; 477S (7/1/79)

MASSACHUSETTS

NONE

MICHIGAN

Individual and group expense incurred contracts shall provide coverage for intermediate and outpatient care for substance abuse. Minimum of $1,500 in benefits per individual per year with minimum adjusted annually with increase or decrease in CPI for preceding year. If premium would be increased 3% or more because of this coverage, insured may decline coverage. §500.3425 (1/1/82)

Group policies shall offer inpatient benefits for substance abuse as shall be agreed upon between insurer and policyholder and shall provide coverage for intermediate and outpatient care as required by §500.3425. Also applies to Blues. §500.3609 (7/1/74; 1/1/82)

MINNESOTA

Every group contract and group nonprofit health service contract, upon issuance or renewal, shall provide for payment of benefits for treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident covered thereunder on same basis as coverage for other benefits when treatment rendered in a licensed hospital, licensed residential treatment program pursuant to diagnosis or recommendation by M.D., nonresidential treatment program approved or licensed by state. Same coverage required for individual contracts subject to insured refusal in writing. §62A.149 (4/6/78)

MISSISSIPPI

NONE

MISSOURI

All contracts shall offer benefits for alcoholism, chemical dependency and drug addiction which cover (1) residential treatment, (2) nonresidential treatment. Benefits may be limited to 80% of reasonable charges to maximum of $2,000 per benefit period. Insured may reject, or elect coverage for (1) or (2) or both. §376.779 (12/31/80)

MONTANA

Insurers and health service corporations' hospital and medical expense contracts must make available benefits for care and treatment of mental illness, alcoholism and drug addiction on same basis as other benefits, except inpatient benefits may be limited to 30 days per year; outpatient to $1,000 per benefit period; and maximum lifetime benefits to $10,000 or 25% of lifetime contract limit whichever is less. Does not apply to blanket, shortterm travel, accident only, limited or specified disease, individual conversion or Medicare Supplement contracts. §33-22-701 (10/29/79; 1/1/82)

On effective date, amends above to require group/health service corporations' hospital and medical expense contracts to provide minimum aggregate benefit levels. Treatment plans approved by "chemical dependence counselors" (i.e., can't require physician approval). §33-22-701 (12/31/84)

NEBRASKA

NONE

NEVADA

Individual policies must provide optional coverage as follows: (1) treatment for withdrawal of physiological effects of alcohol or drugs for at least 7 days per calendar year; (2) inpatient treatment with maximum of $10,000 per

NEVADA (continued)

calendar year; (3) outpatient treatment for individual, group and family counseling to $1,500 per calendar year. Insured entitled to 3 courses of each type of treatment in (1), (2), (3) during insured's lifetime. Insured entitled to benefits if treatment provided in facility for treatment of abuse of alcohol or drugs certified by Bureau of Alcohol and Drug Abuse, or any hospital or other health and care facility licensed by the Health Division of Department of Human Resources, accredited by Joint Commission on Accreditation of Hospitals, and providing a program for such treatment as part of its accredited activities. §689A.030 (7/1/83)

Same benefits mandated for group policies. §689B.037 (7/1/83)

NEW HAMPSHIRE

NONE

NEW JERSEY

NONE

NEW MEXICO

NONE

NEW YORK

NONE

NORTH CAROLINA

Group or blanket contracts issued, renewed, or amended on or after January 1, 1985 must make available coverage for care and treatment of chemical dependency not less favorable than offered benefits for physical illness in general. §58-251.8

NORTH DAKOTA

Requires 70 days inpatient; 140 days outpatient--group, blanket and franchise contracts of 50 lives and which cover 70% or more of group. §26-39-01; Bul. 30 (7/1/75)

OHIO

NONE

OKLAHOMA

NONE

OREGON

Mandates benefits in group policies for alcoholism, chemical dependency and mental illness. Benefits must be provided whether performed in health or residential facilities, or on outpatient basis, or by physicians, psychologists, nurse practitioners, or clinical social workers. May be subject to provisions of policy applicable to other benefits, including coinsurance and deductibles, except that coinsurance and deductibles for treatment in health or residential facilities may not be greater than for hospitalization, and for outpatient treatment, may not be greater than for other outpatient treatment. Total benefit dollar amounts may be limited depending on whether services are for alcoholism, chemical dependency, mental illness, or combination thereof, or whether provided in health or residential facilities, or outpatient basis, or combination thereof. Insurers allowed option of implementing certain "cost containment" features. §§743.557 & .558 (1/1/84; sunsets 7/1/87)

PENNSYLVANIA

NONE

RHODE ISLAND

NONE

SOUTH CAROLINA

NONE

SOUTH DAKOTA

NONE

TENNESSEE

Unless specifically excluded, individual, group, franchise, or blanket contracts must provide benefits for psychiatric disorders, mental or nervous conditions, alcoholism, drug dependence or medical complications of mental illness or mental retardation. Benefits not defined but must be provided for services rendered in health facility licensed in state as hospital accredited by Joint Commission on Accreditation of Hospitals, or facility owned or operated by state which is especially intended for diagnosis, care and treatment of psychiatric, mental or nervous disorders, or licensed and accredited residential treatment facility. §§56-7-1003 & 1004 (7/1/74; 7/1/81)

TENNESSEE (continued)

Group hospital, medical or major medical contracts shall make available outpatient benefits in community mental health centers which shall include minimum of 30 outpatient visits per year and deductibles and coinsurance not less favorable than illness generally. Benefits shall be part of contract unless policyholder rejects in writing. If contract provides inpatient benefits, shall include community mental health centers with inpatient care facilities. §§56-7-1003 & 1004 (7/1/80)

Group hospital/medical expense incurred contracts shall offer and make available benefits for necessary care and treatment of alcoholism and drug dependency no less favorable than for physical illness generally, with same durational and dollar limits, deductibles and coinsurance factors. Alcohol or drug dependency treatment center benefits same as if in hospital. Such centers defined. Group policyholder may reject such coverage or select any alternative level of benefits that might be offered or negotiated with insurer. Applies to group contracts issued in state more than 120 days after effective date. Does not apply to blanket, short-term travel, accident only, limited or specified disease, individual conversion or Medicare supplement contracts. §§56-7-1001 through 1008 (10/1/82)

When optional benefits offered under §56-7-1003 are provided for mental, emotional or nervous disorders, alcoholism, drug dependence or medical complication of mental illness or mental retardation, and treatment is received at community mental health center, such benefits provided when services are rendered by a physician shall also be provided when rendered by a member of the clinical staff of the community mental health center provided the center has in effect a plan for quality assurance approved by the Department of Mental Health, and such treatment is supervised by licensed physician or clinical psychologist. §56-7-1003(b) (6/5/84)

TEXAS

Group, service contracts, HMOs - NAIC 6/81 model on availability of alcoholism and other drug dependency coverage. Art. 3.51-9 (1/1/82)

UTAH

NONE

VERMONT

NONE

VIRGINIA

Individual and group contracts shall include benefits for drug and alcohol rehabilitation and treatment in the 30-day period of coverage of inpatient care specified for mental, emotional or nervous disorders. Level of coverage for benefits for drug and alcohol rehabilitation only may be different provided such benefits cover reasonable cost for necessary services and may be limited to 90 days active inpatient treatment in covered person's lifetime. §38.1-348.7 (7/1/79)

Group contracts shall offer as option alcoholism or drug treatment benefits same as illness with minimum benefits 45 days in alcoholism or drug treatment facility or intermediate facility, 45 sessions of outpatient individual, group or family counseling. §38.1-348.8 (7/1/78)

WASHINGTON

NONE

WEST VIRGINIA

NONE

WISCONSIN

Group contracts must include at least 30 days inpatient; outpatient up to $500 per year. §632.89 (9/1/74)

WYOMING

NONE

PUERTO RICO

NONE

ALABAMA

Group, blanket, franchise, nonprofit indemnity, group-type self-insurance and HMO contracts must offer elective alcoholism benefit. Minimum benefits include 30 days inpatient treatment or its equivalent per calendar year. Equivalency computed to equate 2 days treatment in short-term residential alcoholism treatment facility or 3 sessions of outpatient treatment by M.D. or alcoholism treatment facility to 1 day inpatient treatment. §27-20A-1 et seq (7/19/79)

ALASKA

NONE

ARIZONA

If contract provides coverage for alcoholism, drug abuse or psychiatric services, reimbursement shall be made whether covered service rendered in general hospital or psychiatric special hospital. Applies to contracts delivered on or after 1/1/80 and to existing group contracts thereafter on renewal, anniversary date or expiration of collective bargaining agreement. §§20-841; 20-934; 20-1057; 20-1376; 20-1406 (1/1/80)

ARKANSAS

NONE

CALIFORNIA

Group medical expense insurers must offer alcoholism coverage as may be agreed upon between insurer and policyholder. The availability of such coverage must be communicated to all group and prospective group policyholders. Same requirement for health care service and hospital service plans. §10123.6 (1/1/79)

COLORADO

Group must offer 45 days inpatient and $500 outpatient; coinsurance up to 50%. Each day of confinement shall reduce days covered under contract for illness and for minimum mental illness coverage. §10-8-301 (1/1/76)

CONNECTICUT

Group hospital or medical expense contracts must include same coverage for hospital confinement as for any other disease; minimum of 45 days in "treatment facilities." §38-262b (5/10/74)

Group contracts must offer outpatient benefits. §38-262f (10/1/77)

DELAWARE

NONE

DISTRICT OF COLUMBIA

NONE

FLORIDA

Group health insurers shall make available, if required by policyholder, specified level of benefits for necessary care and treatment of alcoholics--optional coverage. Policyholder may select alternate levels of benefits. Basic benefit defined as intensive treatment program for treatment of alcoholism with minimum lifetime benefit of $2,000, allowable maximum of 44 outpatient visits, and outpatient visit benefits not to exceed $35. Does not apply to individual, short-term travel, accident only, limited or specified disease, individual conversion or contracts issued to persons eligible for Medicare. §627.669 (1/1/80; amd. 1981)

GEORGIA

NONE

HAWAII

NONE

IDAHO

NONE

ILLINOIS

Group contract with in-hospital coverage for sicknesses cannot exclude treatment of alcoholism from such coverage. Does not apply to contracts covering specified sicknesses only. §367(8) (10/1/73)

INDIANA

NONE

IOWA

NONE

KANSAS

Unless refused in writing, group insurers must provide coverage for treatment of alcoholism, drug abuse or nervous or mental conditions for no less than 30 days per year in licensed hospital or facility and outpatient benefits limited to not less than 100% of first $100 and 80% of next $500 in any year. §40-2,105 (7/1/78)

KENTUCKY

Group contracts providing major medical or outpatient benefits must offer option to purchase minimum benefits for alcoholism emergency detoxification, residential or outpatient treatment. Treatment in acute care hospitals licensed by state and accredited by hospital commission shall be treated by all health care carriers as any other disease covered in contracts. §§304.32.158; 304.38.197 (1/1/79)

Also applies to group contracts issued by nonprofit hospital, medical-surgical or health service corporations or HMOs. §§304.18.130; .140; .160 (7/15/80)

LOUISIANA

Group, blanket, franchise contracts to include as option coverage for treatment of alcoholism and drug abuse rendered or prescribed by physician licensed in state, received in hospital or any other public or private facility including freestanding, nonhospital based treatment and rehabilitation programs. Contracts in force 10/1/82 shall provide such option. §22:215.5 (7/1/75; 9/1/82)

MAINE

Group, blanket and nonprofit hospital or medical service corporations shall provide annual benefits for alcoholism and drug dependency to include: residential treatment--30 days except need not exceed total policy inpatient days, coinsurance lesser of 90% or level provided for any other illness, maximum lifetime benefit of 60 days; outpatient--$1,000, coinsurance lesser of 80% or level provided for any other illness, $100 deductible, lifetime maximum $25,000 except need not exceed policy total maximum. Persons covered under both basic and major medical policies may not "stack" benefits of both policies. Policy may limit or exclude benefits to extent coverage would duplicate and be secondary to Medicare but must cover difference between Medicare and minimum required benefits. 24-A§2842 (9/23/83); Rule C. 320 (6/1/84)

MARYLAND

Group expense incurred contracts and nonprofit health service plans must provide minimum benefits for alcoholism treatment in calendar/policy year; to include 7 days emergency care, 30 days in type C or D facility; 30 days

MARYLAND (continued)

outpatient group major medical contracts providing hospital/medical care must provide benefits equal to at least one-half those required. Overall benefits may be limited to 120 days or visits combined in covered person's lifetime and maximum outpatient benefit in calendar or benefit period may be limited to $1,000. 48A§490F (7/1/81)

MASSACHUSETTS

Group and blanket contracts must provide as minimum benefits: inpatient hospitalization benefits of 30 days in any calendar year, such benefit extended to residential alcohol treatment programs in group contracts; outpatient benefits of a maximum of $500 over a 12-month benefit period. C. 175 §110(H) (1/1/76; 9/1/82)

MICHIGAN

Individual and group expense incurred contracts shall provide coverage for intermediate and outpatient care for substance abuse. Minimum of $1,500 in benefits per individual per year with minimum adjusted annually with increase or decrease in CPI for preceding year. If premium could be increased 3% or more because of coverage, insured may decline. §500.3425 (1/1/82)

Group contracts shall offer inpatient benefits for substance abuse as shall be agreed upon between insurer and policyholder and shall provide coverage for intermediate and outpatient care as required by §500.3425. Also applies to Blues. §500.3609 (1/1/82)

MINNESOTA

Every group contract and group nonprofit health service contract, upon issuance or renewal, shall provide for payment of benefits for treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident covered thereunder on same basis as coverage for other benefits when treatment rendered in a licensed hospital, licensed residential treatment program pursuant to diagnosis or recommendation by M.D., nonresidential treatment program approved or licensed by state. Inpatient coverage to provide minimum of 20% total patient days, not less than 28 days per 12-month benefit period; outpatient coverage to provide minimum of 130 hours treatment per benefit period. Same coverage required for individual contracts subject to insured refusal in writing. §62A.149 (4/6/78)

MISSISSIPPI

Group contracts must provide benefits on same basis as other illness up to $1,000 per year. §§83-9-27; 83-9-29; 83-9-30 (1/1/75)

MISSOURI

Individual, group, health service corporation, and self-insured plans providing hospital treatment shall provide coverage for treatment of alcoholism on same basis as other illness, except may be limited to 30 days in any benefit period. All contracts shall offer benefits for alcoholism, chemical dependency and drug addiction which cover (1) residential treatment, (2) non-residential treatment. Benefits may be limited to 80% of reasonable charges to maximum of $2,000 per benefit period. Insured may reject, or elect coverage for (1) or (2) or both. §376.779 (12/31/80)

MONTANA

Insurers and health service corporations' hospital and medical expense contracts must make available benefits for care and treatment of mental illness, alcoholism and drug addiction on same basis as other benefits, except inpatient benefits may be limited to 30 days per year; outpatient to $1,000 per benefit period; and maximum lifetime benefits to $10,000 or 25% of lifetime policy limit whichever is less. Does not apply to blanket, short-term travel, accident only, limited or specified disease, individual conversion or Medicare Supplement contracts. §33-22-701 (10/29/79; 1/1/82)

On effective date, amends above to require group/health service corporations' hospital and medical expense contracts to provide minimum aggregate benefit levels. Treatment plans approved by "chemical dependence counselors" (i.e., can't require physician approval). §33-22-701 (12/31/84)

NEBRASKA

Group hospital service and HMO contracts which do not provide basic coverage of 30 days inpatient treatment in 1 year period with 2 such periods in contract lifetime and 60 outpatient visits in contract lifetime must so inform applicants and insureds. Must offer some coverage if specifically requested at terms and conditions agreed upon between insurer and insured, but may provide different or lesser benefits. §§44-770 through 781

NEVADA

HMO and hospital and medical service contracts must provide optional coverage for alcoholism which includes: (1) if provide inpatient benefits--not less than 5 days room and board; (2) if provide inpatient benefits in health care facility--minimum of 30 days with maximum benefit of $1,000; (3) if provide major medical--outpatient treatment in health care facility for at least 52 visits with maximum benefit of $800 provided treatment commences within 7 days after completion of inpatient treatment. Law unclear as to whether minimum benefits are annual. Also requires provision of "two such episodes" of treatment plus an additional 60 days outpatient coverage. §§695B.180; 695C.170 (7/1/79); HIAA IDB Nev. 1-75

NEVADA (continued)

Individual policies must provide optional coverage as follows: (1) treatment for withdrawal of physiological effects of alcohol or drugs for at least 7 days per calendar year; (2) inpatient treatment with maximum of $10,000 per calendar year; (3) outpatient treatment for individual, group and family counseling to $1,500 per calendar year. Insured entitled to 3 courses of each type of treatment in (1), (2), (3) during insured's lifetime. Insured entitled to benefits if treatment provided in facility for treatment of abuse of alcohol or drugs certified by Bureau of Alcohol and Drug Abuse, or any hospital or other health and care facility licensed by the Health Division of Department of Human Resources, accredited by Joint Commission on Accreditation of Hospitals, and providing a program for such treatment as part of its accredited activities. §689A.030 (7/1/83)

Same benefits mandated for group policies. §689B.037 (7/1/83)

NEW HAMPSHIRE

NONE

NEW JERSEY

Individual and group must provide for inpatient and outpatient in licensed hospital, detoxification facility or state approved facility same as any other sickness. §§17B:26-2.1; 17B:27-46 (6/2/77)

NEW MEXICO

Group/health care plans must offer coverage of 30 days treatment in alcohol dependency treatment center and 30 outpatient visits, with benefit periods of no more than one year and lifetime maximum of two benefit periods. §59-18-24 (7/1/83)

NEW YORK

Up until September 1, 1984, requires that, for group insurance contracts providing coverage on an inpatient basis, make available, if requested, coverage for inpatient detoxification not less than 7 days per calendar year, and rehabilitation care not less than 30 days and 30 outpatient visits. After September 1, 1984, provision extended to blanket contracts. Also after September 1, 1984, such group and and blanket contracts must provide 60 outpatient visits of which 20 are for family members. The latter provision does not apply to policies covering persons employed in more than 1 state, nor to collectively bargained contracts. Latter provision also may use coinsurance and deductibles deemed appropriate by Superintendent as consistent with other policy benefits and may not replace other policy benefits. New §§3221(k)(6) & (7); 4303 [§§162.17; 162.17-a] (1981; 1983; 9/1/84)

NORTH CAROLINA

Group or blanket contracts issued, renewed, or amended on or after January 1, 1985 must make available coverage for care and treatment of chemical dependency not less favorable than offered benefits for physical illness in general. §58-251.8

NORTH DAKOTA

Requires 70 days inpatient; 140 days outpatient--group, blanket, and franchise contracts over 50 lives and which cover 70% or more of group. §26-39-01 (7/1/75); Bul. 30

OHIO

Group medical expense contracts, other than accident only or specified disease, must provide benefits for alcoholism on outpatient, inpatient or intermediate primary care basis equal to $550 in any 12-month period. §3923.29 (1/1/79; 1/1/83)

OKLAHOMA

NONE

OREGON

Individual contracts must provide at request of applicant, coverage not less than $4,500 in any 24-month period and, within that limit, coverage of no less than 80% of hospital and medical expenses. Contracts must cover services rendered by licensed or accredited health care facilities and rehabilitation clinics and agencies. §743.412 (10/4/77; 11/1/81)

Mandates benefits in group policies for alcoholism, chemical dependency and mental illness. Benefits must be provided whether performed in health or residential facilities, or on outpatient basis, or by physicians, psychologists, nurse practitioners, or clinical social workers. May be subject to provisions of policy applicable to other benefits, including coinsurance and deductibles, except that coinsurance and deductibles for treatment in health or residential facilities may not be greater than for hospitalization, and for outpatient treatment, may not be greater than for other outpatient treatment. Total benefit dollar amounts may be limited depending on whether services are for alcoholism, chemical dependency, mental illness, or combination thereof, or whether provided in health or residential facilities, or outpatient basis, or combination thereof. Insurers allowed option of implementing certain "cost containment" features. §§743.557 & .558 (1/1/84; sunsets 7/1/87)

PENNSYLVANIA

NONE

RHODE ISLAND

All expense incurred contracts shall provide: inpatient--detoxification benefits not to exceed 7 days per occurrence, with no more than 3 such occurrences per year; rehabilitation services for 30 days in any 12-month period; outpatient--30 hours for each individual under treatment and 20 hours for remaining family members in any 12-month period. Lifetime benefit of 90 days for rehabilitative services. (Note: Also see HIAA IDB Rhode Island 1-81 and 3-81 for Department guidelines). §27-38-1 (10/1/80)

SOUTH CAROLINA

NONE

SOUTH DAKOTA

Any insurer providing coverage on expense incurred basis must offer, in writing, in contracts issued or renewed after 7/1/79, coverage for inpatient treatment of alcoholism in licensed hospitals and residential primary treatment facilities approved by state, carrying out program pursuant to diagnosis and recommendation of M.D. Group offer to include inpatient therapy and treatment in approved inpatient alcoholism treatment facility. Group benefit level on same basis as other benefits but need not exceed 30 days care in any 6-month period and care per recipient need not exceed 90 days during life of contract. Does not apply to group major medical, or accident only, limited or specified disease contracts. §§58-17-30.5 through 30.7; 58-18-7.1; 58-38-11.1 & .2; 58-40-10.1; 58-41-35.1 (7/1/79; 7/1/82)

TENNESSEE

Unless specifically excluded, individual, franchise, blanket or group contracts must provide benefits for psychiatric disorders, mental or nervous conditions, alcoholism, drug dependence or medical complications of mental illness or mental retardation. Benefits not defined but must be provided for services rendered in health facility licensed in state as hospital accredited by Joint Commission on Accreditation of Hospitals, or facility owned or operated by state which is especially intended for diagnosis, care and treatment of psychiatric, mental or nervous disorders, or licensed and accredited residential treatment facility. §§56-7-1003 & 1004 (7/1/74; 7/1/81)

Group hospital, medical or major medical contracts shall make available outpatient benefits in community mental health centers which shall include minimum of 30 outpatient visits per year and deductibles and coinsurance not less favorable than illness generally. Benefits shall be part of contract unless policyholder rejects in writing. If contract provides inpatient benefits, shall include community mental health centers with inpatient care facilities. §§56-7-1003 & 1004 (7/1/80)

TENNESSEE (continued)

Group hospital/medical expense incurred contracts shall offer and make available benefits for necessary care and treatment of alcoholism and drug dependency no less favorable than for physical illness generally, with same durational and dollar limits, deductibles and coinsurance factors. Alcohol or drug dependency treatment center benefits same as if in hospital. Such centers defined. Group policyholder may reject such coverage or select any alternative level of benefits that might be offered or negotiated with insurer. Applies to group contracts issued in state more than 120 days after effective date. Does not apply to blanket, short-term travel, accident only, limited or specified disease, individual conversion or Medicare supplement contracts. §§56-7-1001 through 1008 (10/1/82)

When optional benefits offered under §56-7-1003 are provided for mental, emotional or nervous disorders, alcoholism, drug dependence or medical complication of mental illness or mental retardation, and treatment is received at community mental health center, such benefits provided when services are rendered by a physician shall also be provided when rendered by a member of the clinical staff of the community mental health center provided the center has in effect a plan for quality assurance approved by the Department of Mental Health, and such treatment is supervised by licensed physician or clinical psychologist. §56-7-1003(b) (6/5/84)

TEXAS

Group, service contracts, HMOs - NAIC 6/81 model on availability of alcoholism and other drug dependency coverage. Art. 3.51-9 (1/1/82)

UTAH

Group contracts shall contain optional rider which provides coverage for alcoholism treatment or detoxification in licensed facilities or accredited inpatient hospitals. §31-20-2(6) (5/12/81)

VERMONT

Insurers, HMOs, nonprofit hospital and medical service plan corporations shall offer, after additional premium, coverage for alcohol dependency care and treatment under group contracts. 8§§4097 through 5000

VIRGINIA

Individual and group contracts shall include benefits for drug and alcohol rehabilitation and treatment in the 30-day period of coverage of inpatient care specified for mental, emotional or nervous disorders. Level of coverage for benefits for drug and alcohol rehabilitaton only may be different provided such benefits cover reasonable cost for necessary services and may be limited to 90 days active inpatient treatment in covered person's lifetime. §38.1-348.7 (7/1/79)

VIRGINIA (continued)

Group contracts shall offer alcoholism or drug treatment benefits same as illness with minimum benefits 45 days in alcoholism or drug treatment facility or intermediate facility, 45 sessions of outpatient individual, group or family counseling. §38.1-348.8 (7/1/78)

WASHINGTON

Group contracts must provide alcoholism coverage in licensed treatment centers. Benefits not defined. §§48.21.160; .170; .180; .190 (7/1/74); HMOs, §48.46.350 (7/24/83)

WEST VIRGINIA

Group, blanket, franchise, association contracts must give option of alcoholism coverage. Minimum benefits: inpatient--30 days; if providing more than 30 days may use different deductibles, coinsurance and $ limits than rest of contract. Outpatient coinsurance may not exceed 50%; maximum benefit per benefit period not less than $750; lifetime benefits not less than $10,000 or 25% of contract limit, whichever is less. §33-16-3c (7/10/81)

WISCONSIN

Group contracts must provide up to 30 days inpatient; outpatient up to $500. §632.89 (9/1/74)

WYOMING

NONE

PUERTO RICO

NONE

Exhibit 3

Estimated Self-Insured Growth on National Basis

1985	1983	1980	1975
40%	36%	30%	13%

1985 Kansas health insurance premiums were $842,830,000.

If this figure represents 60% of Kansas's health insurance premiums, then 40% would be additional $561,886,664 that is attributed to self-funding mechanisms.

As a result, the potential loss of premium tax to the state of Kansas from self-funding mechanisms is estimated as follows:

Domestic premium tax 1%	$ 5,618,864
Foreign premium tax 2%	11,237,728

Ex 4

Mr. DeCamp asked unanimous consent to print the following amendment to LB 881 in the Journal. No objections. So ordered.

Page 3, line 25, New (6) as follows:

"(6) Subsection (5) of this section shall not be applicable when the tank or container's owner can show that the tank or container has been properly prepared for alternative use. Standards for such preparation shall be adopted and promulgated by the State Fire Marshal pursuant to this section."

Mr. Lynch asked unanimous consent to print the following amendment to LB 895 in the Journal. No objections. So ordered.

AM2397

1. Strike the original sections and all amendments thereto and insert the following new sections:

"Section 1. The Legislature recognizes the increasing number of proposals mandating or offering health care coverages or services by insurance or otherwise, health care service contractors, and health maintenance organizations as a component of insurance policies or employee welfare benefit plans. Improved access to health care services to segments of the population which desire such services can provide beneficial social and health consequences which may be in the public interest.

The cost ramifications of expanding health care coverages and services are a growing concern. The structures of such coverages or services and the steps taken to create incentives to provide cost-effective services or to take advantage of cost-offsetting features of services can significantly influence the cost impact of mandating particular coverages and services.

Sec. 2. For purposes of this act, health care coverages or services shall mean any services rendered for a fee included in the furnishing to any individual of medical or other services incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

Sec. 3. No legislative proposal to mandate or require the offering of health care coverages or services shall apply to any insurer unless the proposal applies equally to employee welfare benefit plans described in 29 U.S.C. 1001, et seq., as amended.".

Solons protest state's dwindling ability to regulate insurance

By James Joyce
of The Lincoln Star

The Legislature is on the verge of passing a bill aimed at preventing itself from passing a law.

Sounds strange, doesn't it? It really isn't.

Nor is it a joke, because it deals with something the senators feel has gotten out of hand, the dwindling ability of the states to regulate medical insurance.

The bill would prohibit the Legislature from mandating insurance companies to provide a specific type of coverage unless the identical service is provided by Medicaid, Medicare, programs for the uninsured, federal employees and others.

Until Tuesday, when the senators voted 25-5 to advance LB895 to final reading, it had been little noticed outside the Legislature except by the insurance industry.

Although sponsored by the Banking, Commerce and Insurance Committee, it is the brainchild of Sen. Dan Lynch of Omaha.

Lynch said the bill's main purpose is to send a message to Congress about what is happening across the nation in the health insurance field.

According to Lynch, who works for Blue Cross-Blue Shield, a federal law passed in the early '70s is squeezing the insurance industry and its policyholders.

The law, referred to in the industry as ERISA (for Employment Retirement Income Security Act), exempts a variety of insurance programs from state regulation and state taxes.

Included among them are health maintenance organizations and organizations, such as major industries like InterNorth, which are self-insured.

The result of this law, he said, is that the pool of people who aren't included in these programs are forced to pay higher premium rates when a specific type of coverage is mandated.

Included among these people are farmers, small businesses that aren't self-insured and individual policyholders who don't belong to one of the federally exempt programs.

In Nebraska, he said, about half the people insured belong to federally exempt programs, and it is estimated that next year 67 percent of the major industries in the nation will be self-insured.

As a practical matter, the bill probably won't have much of an immediate effect in Nebraska. Although there is a long list of mandated coverages, attempts to broaden that list in recent years to such things as mental health treatment and alcoholism treatment have been rejected by the Legislature.

Some companies, even though not required to, provide these types of services, but only those people who specifically have it written into their policies pay for them in their premiums.

"If there is a need for a benefit it simply should apply to everyone," Lynch said.

Opposition to the bill came from senators who feared the precedent. They suggested that insurance companies would use it as justification to reduce the number of coverages already mandated.

Sen. Vard Johnson of Omaha said the state could wind up having no standards for what should be provided and coverage could be determined solely by the marketplace.

If this were to happen, he said, there would be whole groups of people left without coverage for illnesses they couldn't afford to pay for on their own.

"The bad will drive out the good," he said, declaring that the proper way to deal with the problem is to ask the state's Washington delegation to get Congress to reform ERISA.

There were also senators, such as Shirley Marsh of Lincoln, who objected to the Legislature giving up its ability to deal with requests for additional mandated coverage on a case-by-case basis.

"We are trying to close the door for discussion," she said. "We are saying as a legislative body we don't have the self control to look at each individual offering."

WEDNESDAY, MARCH 12, 1986 LINCOLN, NE. JOURNAL

Insurance bill goes to final stage

By The Associated Press

The Legislature on Tuesday gave second-round approval to a bill prohibiting the state from requiring coverages by public health insurance companies unless those services are offered by self-insurance groups.

Concerned that an upswing in state-mandated coverages in public health insurance policies has increased premiums, senators voted 25-5 to send an amended LB895 to the final stage of floor action.

"Nebraska will do more to help the consumer with this legislation than anything it can think of," said Sen. Daniel Lynch of Omaha, sponsor of an amendment that replaced the original version of LB895.

The amended version would prohibit the state from mandating certain coverage by public health insurance companies unless the identical service is provided by Medicaid, Medicare, programs for the uninsured, federal employees and others.

Lynch and Sen. John DeCamp of Neligh said that rising health insurance costs has driven many people to participate in private insurance policies.

However, farmers, small businessmen and individual policyholders often have no choice but to remain with public health insurance firms, which are forced to raise their premiums to offset the dwindling number of customers, the two senators said.

The original bill was introduced by the Banking Committee.

Supporters said that premiums escalate when the state mandates health insurance companies to offer more coverages.

However, opponents said the bill would benefit the health insurance industry and would tie the Legislature's hands in trying to require health insurance coverages that benefit society.

Lawmakers rejected, 8-23, an amendment presented by Omaha Sen. Vard Johnson that sought to strike the requirement that future state mandated services be provided by public and self-insurance groups.

Attachment II

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

Atch. II
S. FII 4/1/86

(As of 7-1-85)

HOUSE BILL #2737

ESTIMATE COSTS

Estimated annual costs to add Out-Patient Psychiatric Rider (First $100 @ 100%; next $100 @ 80%; next $1,640 @ 50%) to Kansas Blue Cross and Blue Shield Contracts currently without coverage and to increase the benefits for those Contracts with lesser Out-Patient Psychiatric benefits:

Category	Number of Contracts	# and % O.P. Rider		Estimated Monthly Rates Single	Family	Estimated Additional Annual Costs Costs
Farm	6,100			2.37	3.97	$ 248,900
Non-Group	10,100			2.37	3.97	368,400
Plan 65	150,800			0.21	----	384,500
Community Group	36,200	(4,104)	11.3%	2.37	3.97	1,324,800
Merit Rated Group	87,100	(14,786)	17.0%	2.37	3.97	3,027,700
State Employee Group	24,635		100.0%	2.37	3.97	227,900
TOTAL						$5,582,200

NOTE: The above rates and annual costs assume benefits would be mandated for all Contracts.

S. EXI 4/1/86
Attachment III

Attachment IV

GROUP: Federal Employee Program

STUDY: COMPARISON OF MONTHLY COSTS OF
NERVOUS & MENTAL BENEFITS vs NON-NERVOUS & MENTAL BENEFITS

1980 ULTIMATE INCURRED CLAIMS FOR 1,370,293 CONTRACTS

	CLAIMS COST PER MONTH			
	(1) Used Services But Not N&M	(2) Used Services Including N&M Benefits	(3) Non N&M Services Used by Those Who Used N&M Services	(4) Cost for N&M for Those Using N&M Services (Column 2 - Column 3)
Contracts				
Single	$ 65.87	$265.19	$ 75.35	$189.84
Family				
Employee	66.15	209.20	78.66	130.54
Spouse	73.69	256.84	114.48	142.36
Non-Spouse Dependent	29.68	266.01	51.79	214.22

Question: Will the addition of Nervous and Mental benefits reduce the total cost of the benefit package?

Comment: The absence of Nervous and Mental benefits would have to cause Column 3 to increase in cost by an amount greater than the amount shown in Column 4.

Att. IV
S. III 4/1/82

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 First National Tower One Townsite Plaza Topeka, KS 66603-3460 (913) 357-6321

A consolidation of the Kansas State Chamber of Commerce, Associated Industries of Kansas, Kansas Retail Council

HB 2737

March 27, 1986

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Financial Institutions and Insurance Committee

by

David S. Litwin

Mr. Chairman and members of the committee, I am David Litwin, representing the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to testify in opposition to HB 2737.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

In the present matter, there appears to be no significant problem for which this bill would provide a solution. Well before 1978, group* outpatient benefits were available. Since the enactment of L. 1978, c. 166, all carriers offering group

*KCCI's interest in this matter is that of employers purchasing group health insurance. Therefore, KCCI does not express a position in favor of or in opposition to those portions of the bill that pertain to individual coverage.

S. FII 4/1/86
Attachment V

hospitalization coverage must offer optional outpatient coverage similar to that set forth in HB 2737. The experience of Blue Cross-Blue Shield, the largest carrier in this area, has been that most groups have specifically elected not to take the optional outpatient coverage.

Thus there is hardly a groundswell of popular opinion behind the campaign to enact this bill. One reason that this bill is being proposed may be that the coverages it would mandate are faring poorly in the open marketplace, because the potential beneficiaries, after being made aware specifically of this kind of courage, have overwhelmingly determined that they simply do not want it.

On the other hand, this bill would significantly add to the costs of those parties (employers, employee groups, etc.) who do buy group health coverage. As the testimony of representatives of the insurance industry has or will indicate, these added costs are substantial. Indeed, the actual costs may be considerably larger than anticipated, due to the fact that unlike other illnesses, in many cases the dividing line between emotional health and illness is not clear and can be quite subjective.

Thus, in short, these bills would appropriate the discretion of employers and employee groups to utilize their health-care funds in the manner they deem most efficient, and at the same time they would add significantly and unpredictably to the costs of health care at a time when health care cost containment is already a grave concern. We suggest that it would be far more appropriate in this matter to let the decision concerning health care fund allocation be made by those who have to pay the freight.

On behalf of KCCI and myself, thank you once again for the opportunity to present our views for your consideration. If there are any questions, I'll be happy to answer them.

DAC Drug and Alcoholism Council of Johnson County
5311 Johnson Drive • Mission, Kansas 66205 • 913/432-8424

TO : Committee Members
Financial Institutions and Insurance

FROM: Sherry Wood, President

DATE: March 24, 1986

RE : Support for HB 2737 (Mandatory Insurance) without the House floor amendment

On behalf of the Drug and Alcoholism Council of Johnson County, a citizen advisory Council, I want to urge your support for HB 2737, calling for mandatory mental-drug-alcohol treatment insurance coverage but only with the deletion of the House floor amendment which exempts any group policy covering group members represented by a labor organization.

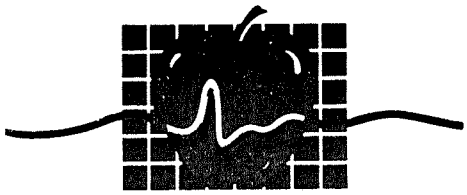
This amendment makes the mandate virtually useless because of the extremely large numbers of Kansans who would not be included in this greatly needed insurance coverage.

In the State of Kansas, we are greatly lacking in needed affordable drug-alcohol treatment services and without insurance coverage, few can afford the average $300 per day treatment which is available. A survey conducted by the Drug and Alcoholism Council identified lack of alcohol/drug insurance coverage as a major reason people did not receive needed treatment. Kansans are already paying more for the untreated problem than it would cost to treat it through mandated insurance.

Please support HB 2737, and support the removal of the House amendment that excludes a large portion of the state work force.

Thank you for giving this important matter your serious consideration.

S. FII 4/1/86
Attachment VI



PrimeHealth

March 26, 1986

Senator Neil H. Arasmith
Chairman
Senate Financial Institutions
& Insurance Committee
State Capitol
Topeka, KS 66603-3460

Dear Senator Arasmith:

I find that I am unable to attend your committee's hearing on House Bill #2737 tomorrow, but would like to comment briefly on the legislation, in this letter.

First, let me state my opposition to the concept of mandated benefits, which more often are intended by proponents to benefit providers rather than recipients of the services. From a purely parochial point of view, it is probably in our economic interest to have our competition required to also include these benefits, but I sincerely believe that mandating benefits usually results in excessive cost increases. Having said that, I strongly support the inclusion of services for mental problems and substance abuse in any comprehensive package of health care benefits. PRIME HEALTH provides greater access to care for these problems than those required by House Bill #2737.

Prepaid health care plans such as PRIME HEALTH provide services rather than reimbursing for services secured elsewhere as does an indemnity carrier. Therefore, the language in House Bill #2737 setting forth dollar limitations is difficult to apply and keep track of in a system such as ours where services are provided on a comprehensive basis for a predetermined monthly fee. I would suggest that Section I(c) be amended to provide that health maintenance organizations be required to provide a comparable level of benefits as determined by the Commissioner of Insurance, or in some other way that would not require the institution of new, expensive administrative procedures that would increase the cost to patients with no corresponding increase in benefits.

6801 E. 117th St. • Kansas City, MO 64134 • 765-6200

S. FII 4/1/86

Attachment VII

I would appreciate your consideration of my concerns, and your making them known to members of your committee as appropriate. Thank you.

Sincerely,

Robert E. Eisler, Jr.
Health Services Director

REE/lk

TESTIMONY ON HOUSE BILL 3097

Before Senate Committee

4/1/86

1. Introduction

2. Passage last year of Multi-bank Holding Company law.

3. Multi-bank Holding Company law was a step in the right direction.

4. House Bill 3097 as amended, allows for contiguous city banking in Johnson County, Kansas.

   A. Savings & loans and credit unions have unlimited branching capabilities and the right to branch into contiguous cities.

5. House Bill 3097 as amended, only applies to contiguous cities and applies only to Johnson County.

6. Johnson County is unique in that its Eastern border is the state line between Kansas and Kansas City, Missouri.

   A. Missouri offers liberal banking laws.

7. Customers and the public are benefited by contiguous city branching.

8. Branching into contiguous cities contributes to the safety and soundness of banking.

9. Branches into contiguous cities is a consumer issue.

10. Allows banks to remain competitive and serve its customers as they move to different locations in Johnson County.

S. FII 4/1/86
Attachment VIII

Franklin Savings opens branches in area K marts

By JON BARNES

Today's shopping list:

- batteries
- socks
- an IRA

"Convenience banking" has come to Wichita with the opening last week of four branch offices of Franklin Savings Association in Wichita K mart stores.

Each 136-square-foot branch is staffed by one full-time and one part-time employee who will help customers open new accounts or make deposits and withdrawals.

Automatic teller machines are expected to be installed by June.

The K mart branches will be the first time many Wichita residents will have heard of Ottawa-based Franklin, despite that it's the state's largest thrift with $3.4 billion in assets.

The thrift's plans to open a main branch in Wichita by the end of the year will swing on the success of the K mart offices, said Ed Barnes, Franklin vice president for marketing.

If customer traffic is heavy at the K mart locations, the thrift might speed up its plans for a full-service branch in Wichita, he said.

No site has been determined, but the branch probably will be centrally located, in or near downtown, he said.

The main Wichita branch would offer all the services Franklin's other branches currently offer, including consumer loans and mortgages, which are not available at the store branches.

Franklin operates in nine Kansas cities in addition to Wichita, and plans to open another branch in Leawood this summer. *It also has an agreement to merge with* First Federal Savings and Loan of Coffeyville.

The Wichita branch openings mark the 13th state in which K mart stores house financial facilities, said Jon Hartman, K mart director of financial services. He said 225 K mart stores across the country now offer some type of financial services. K mart's goal is to have insurance centers, full-service banks, discount brokerages, consumer loan branches, mortgage lending units and real estate offices available in at least 1,000 stores nationwide.

The idea for branch offices such as Franklin's originated with the First Nationwide Network, an association of 27 financial institutions across the country. Franklin joined the network last November.

The Franklin offices are patterned after First Nationwide's offices in California K mart stores. The program was tested first with 10 branch offices in San Diego.

When the program recently expanded to Sacramento, First Nationwide's president estimated that each new K mart branch would mean about $500,000 in new deposits.

The in-store branches are designed to look like the outside of a bank, with pillars and a message board.

"This was not designed for Franklin, but it looks like it was," Barnes said.

Other First Nationwide members in three or four states also are planning to open offices in K marts, he said.

If the Wichita branches prove successful, Franklin will consider opening similar offices in other Kansas cities.

Max Bauman, financial service representative in the K mart branch at 4830 S. Broadway, said a lot of shoppers had stopped by during the first week to ask about rates and services, but by Thursday he had opened no new accounts.

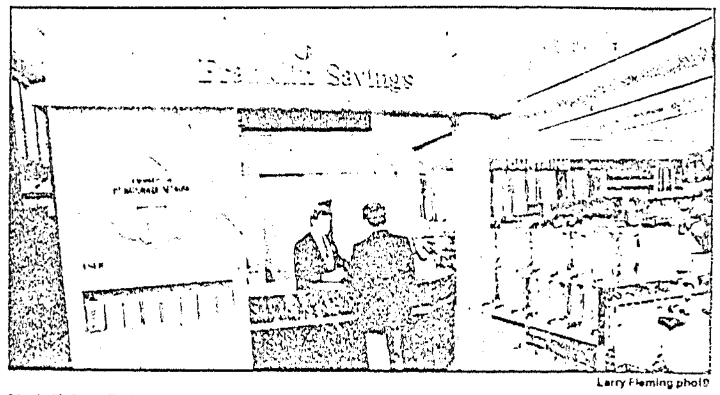
The branch is located between the store's sporting goods and electronics sections.

"We found out through studies in K marts that every class of person shops at K mart," he said.

Gene Hill, manager of the Broadway K mart, said the arrangement would draw customers into the store as well as bring new customers to Franklin.

Hill said rearranging the store to accommodate the thrift was not difficult, and involved only taking out a couple of counters.

Other offices are located in K marts at 4200 W. Kellogg, 8600 E. Kellogg and 5010 E. 21st. The branches will be open 10 a.m. to 7 p.m. Mondays and Tuesdays, 10 a.m. to 9 p.m. Wednesdays, Thursdays and Fridays, and 10 a.m. to 7 p.m. Saturdays.



Larry Fleming photo

Mark Holten (behind counter) and David Daly at Franklin Savings branch in East Kellogg K mart store. Convenience comes to Wichita.

Am Banker 3/28/86

Top 100 Thrifts in Net Income

In Order of 1985 Net Income, Compared with 1984

Compiled by American Banker Copyright 1986

Rank 1985		Net Income 1985	Net Income 1984	% Change	Assets 12/31/85	R.O.A. 1985
1	Home Savings of America, FA, Irwindale, Calif.	236,311,000	57,046,000	314.25	26,746,193,000	0.88
2	Great Western Savings, FS&LA, Beverly Hills	203,857,000	101,290,000	101.26	25,049,203,000	0.81
3	Gibraltar Savings Assn., Houston (a)	169,600,000	33,061,000	413.60	5,066,738,484	3.35
4	World Savings, FS&LA, Oakland, Calif.	159,375,000	84,501,002	88.61	12,134,626,000	1.31
5	CrossLand Savings FSB, Brooklyn, New York	148,365,000	N.A.	.....	8,022,494,000	1.85
6	Columbia Savings & Loan Assn., Beverly Hills	122,277,525	44,064,000	177.50	6,463,336,112	1.89
7	California Fed. Savings & Loan Assn., Los Angeles	115,400,000	69,010,000	67.22	18,002,000,000	0.64
8	American Savings & Loan Assn., Stockton, Calif.	84,254,000	N.A.	.....	27,364,650,000	0.31
9	Lincoln Savings & Loan Assn., Irvine, Calif.	79,850,000	11,200,000	612.95	3,211,758,000	2.49
10	First Nationwide Savings, FS&LA, San Francisco	75,769,000	29,400,000	157.72	11,572,000,000	0.65
11	Home Fed. Savings & Loan Assn. of San Diego, Calif.	72,786,000	62,721,675	16.05	10,018,646,000	0.73
12	First Texas Savings Assn., Dallas	68,248,234	9,969,667	584.56	3,716,266,251	1.84
13	Standard Federal Bank, Troy, Mich.	68,011,482	27,339,477	148.77	5,395,607,977	1.26
14	PSFS, Philadelphia (b)	64,618,000	71,991,000	-10.24	17,153,011,000	0.38
15	Guardian Savings & Loan Assn., Houston	63,809,881	4,727,000	1249.90	2,511,546,511	2.54
16	City Federal Savings & Loan Assn., Elizabeth, N.J.	62,110,000	66,118,000	-6.06	8,224,809,000	0.76
17	First Federal of Michigan, Detroit	55,679,543	30,116,447	84.88	10,195,907,942	0.55
18	Glendale Federal Savings & Loan Assn., Calif. (c)	55,601,000	26,013,000	113.74	14,751,119,000	0.38
19	Downey Savings & Loan Assn., Costa Mesa, Calif.	52,757,661	13,521,000	290.19	2,612,202,618	2.02
20	Great American First Savings Bank, San Diego, Calif.	49,516,000	23,208,000	113.36	8,271,797,000	0.60
21	Green Point Savings Bank, Brooklyn, New York	49,014,921	21,338,759	129.70	2,645,874,024	1.85
22	Long Island Savings Bank FSB, Syosset, N.Y.	46,087,000	24,373,000	89.09	4,710,782,000	0.99
23	Gibraltar Savings, Beverly Hills	46,058,000	36,339,872	26.74	9,539,324,000	0.48
24	Citicorp Savings, FS&LA, San Francisco	44,768,000	13,944,282	221.05	4,408,892,000	1.02
25	Vernon Savings & Loan Assn., Tex.	41,502,753	N.A.	.....	1,145,435,698	3.62
26	Western Savings & Loan Assn., Phoenix, Ariz.	37,749,000	13,128,747	187.53	4,808,899,000	0.78
27	CenTrust Savings Bank, Miami	36,636,000	93,260,399	-60.72	4,809,876,000	0.76
28	Franklin Savings Assn., Ottawa, Kan.	35,353,000	N.A.	.....	3,161,680,000	1.12
29	Investors Savings & Loan Assn., Millburn, N.J.	34,128,461	15,263,312	123.60	2,049,236,570	1.67
30	People's Bank-Bridgeport, Conn.	33,612,000	10,661,000	215.28	4,235,914,000	0.79
31	Northeast Savings, FA, Hartford, Conn. (d)	31,508,000	1,585,000	1887.89	4,492,075,000	0.70
32	Citicorp Savings of Florida, FS&LA, Miami	30,647,000	N.A.	.....	3,270,777,000	0.94
33	MeraBank, FSB, Phoenix, Ariz. (e)	29,092,000	19,049,327	52.72	5,219,438,000	0.56
34	Empire of America FSB, Fort Worth, Tex.	28,812,000	....	.....	2,619,632,000	1.10
35	Washington Federal Savings & Loan Assn., Seattle	28,719,000	22,146,000	29.68	1,033,262,000	2.78
36	Sunbelt Savings Assn., Dallas	27,737,000	N.A.	.....	2,999,870,000	0.92
37	Fidelity Federal S & L Assn., Glendale, Calif.	27,514,000	6,890,000	299.91	3,143,051,000	0.88
38	Bank Western, Denver (f)	26,716,000	N.A.	.....	2,951,439,000	0.91
39	Midwest Federal Savings & Loan Assn., Minneapolis	26,642,567	15,040,471	77.14	3,009,841,394	0.83
40	Anchor Savings Bank FSB, Northport, N.Y. (g)	26,209,000	(16,720,000)	240.01	6,418,498,000	0.41
[illegible]	[illegible] Federal Savings & Loan Assn., Chicago	[illegible]	[illegible]	[illegible]	1,553,464,197	1.63

28th in entire U.S.

THESE TWO ARTICLES, THREE DAYS APART, MAKE AN INTERESTING COINDENCE!

DOES THE LEGISLATURE TRULY BELIEVE ALL FINANCIAL INSTITUTIONS ARE BEING TREATED EQUALLY AND FAIRLY?

S. FII 4/1/86

Attachment IX

Kansas Independent Bankers Association Inc.
P.O. Box 389 • Carbondale, Kansas 66414 • 913/564-9287

DATE: April 1, 1986

TO: Senate Committee on Financial Institutions & Insurance

RE: Opposition to H.B. 3097

Mr. Chairman and members of the Committee. I am Pete McGill, lobbyist for the Kansas Independent Bankers Association. Thank you for the opportunity to appear before you this morning.

As House Bill 3097 was originally introduced in the House, we found little support for or opposition to its adoption. Perhaps somewhere in urban Kansas there is need for bank trust services in branch facilities. It is the opinion of KIBA that few banks would have need for such a law.

However, our principle concern is the amendment to HB 3097 which would permit Johnson County banks to branch into contiguous cities.

There appears to be little acceptance of this amendment by even Johnson County bankers and understandably so. Few bankers would relish a neighboring bank locating an office in the middle of their own bank's trade territory unless it were a capitalized, chartered bank.

S. FII 4/1/86
Attachment X

Currently, a capitalized, chartered bank can be established anywhere in the state of Kansas. With few restrictions, this can be done by a bank holding company, investors, partnerships, community citizens, and individuals. Therefore, if there is a need for further services in Johnson county, the Kansas Banking Department (in the case of a state bank) or the Office of the Comptroller of the Currency (in the case of a national bank) can grant a new charter if the criteria are met for the safety, soundness, and success of the institution.

I urge you to not be hasty in legislating additional changes in Kansas bank structure. Evaluate where we are before you chart yet another course. Multibank holding companies were legalized in 1985. As of this Session, limited branch banking is now authorized for small towns whose sole bank was lost due to bank failure. With a sagging Kansas economy and other current considerations, it seems prudent to allow Kansas banks time to adjust to the new climates created before considering any further structure change.

With these things in mind, the Kansas Independent Bankers Association respectfully requests the removal of the contiguous city branching amendment from HB 3097. Thank you for your attention and consideration of this testimony.

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