Approved: 2/22/94
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Richard Bond at 9:09 a.m. on February 21, 1994 in Room 529-S of the Capitol.

Members present: Senators Corbin, Hensley, Lawrence, Lee, Petty, Praeger, and Steffes.

Committee staff present: William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
June Kossover, Committee Secretary

Conferees appearing before the committee: Donald L. Wilson, Kansas Hospital Association
Cheryl Dillard, Kaiser Permanente
James Schwartz, Kansas Employer Coalition on Health
Jerry Slaughter, Kansas Medical Society
Larry Magill, Kansas Association of Insurance Agents
Brad Smoot, Blue Cross/Blue Shield
Keith Landis, Christian Science Committee on Publication

Others attending: See attached list

Senator Steffes made a motion, seconded by Senator Lawrence, to approve the minutes of the meeting of February 18 as submitted. The motion carried.

The chairman reopened the hearing on **SB 622**, health benefit plans available to small employers, which was originally heard in committee on February 10. Don Wilson, Kansas Hospital Association, appeared as a proponent of this legislation, stating that it is an important step toward health care reform in Kansas and allows the state to begin reform efforts that clearly will be a part of whatever federal reform ultimately passes. (Attachment #1.) Senator Bond asked whether Mr. Wilson could provide any ideas on how to structure the legislation so that alliances would not fail and Mr. Wilson stated that reinsurance was a possibility, either on the alliance side or the provider side. In response to Dr. Wolff's question, Mr. Wilson stated that putting alliances under the auspices of the Insurance Commissioner was also a possibility.

Cheryl Dillard, Kaiser Permanente, appeared in support of **SB 622**, but urged the committee to amend the bill so that provider networks would have to obtain a certificate of authority under the Kansas HMO law (Attachment #2). Senator Bond questioned whether holding provider networks to standards of HMO's would provide as much protection as reinsurance and Ms. Dillard replied that HMO's have general fiscal responsibility parameters which must be met, and that the primary concern is that the consumer must be protected.

James Schwartz, Kansas Employer Coalition on Health, appeared in general support of this legislation, but stressed that alliances' success should stem from improved efficiencies in medical services and administration, rather than from shifting costs, reducing benefits, or avoiding taxes (Attachment #3.)

Jerry Slaughter, Kansas Medical Society, appeared as a proponent of **SB 622**, stating that the bill would provide the same flexibility and control to groups of small employers that larger, self-insured employers currently enjoy. (Attachment #4.) Mr. Slaughter also stated his opinion that requirements for financial responsibility should be in proportion to tasks undertaken.

Larry Magill, Kansas Association of Insurance Agents, appeared before the committee to testify in support of **SB 622**, stating that his group supports the concept of voluntary, competing alliances or health insurance purchasing cooperatives as a means of providing smaller business with the buying power that large firms enjoy. However, Mr. Magill voiced serious concerns that if claims reserves are not adequately set and trend factors not accurately predicted, the alliance could become insolvent before its sponsors realize it, leaving the employers and employees to pay the claims. Mr. Magill proposed amendments to delete the group self-insurance option. (Attachment #5.) In response to Senator Steffes' question, Mr. Magill stated that this bill, as it is written, could have a substantial negative impact on the insurance industry by creating different groups of insurers.

Brad Smoot, Blue Cross/Blue Shield, appeared in opposition to this legislation, stating that by permitting small employers to bypass insurance companies and insurance laws, the bill essentially deregulates private group health insurance and, if we are going to deregulate, he proposed an amendment to delete several Kansas insurance laws designed for the regulation of the insurance industry. (Attachment #6.).

Keith Landis, Christian Science Committee on Publication, requested an amendment on page 1, line 35 to add "or permitted" after "recognized," which would take care of the needs of Christian Science practitioners. (Attachment #7.)

Written testimony was submitted by Paul Klotz, Assn. of Community Mental Health Centers (Attachment #8), Chip Wheelen, Kansas Psychiatric Society, (Attachment #9), Terry Larson, Kansas Alliance for the Mentally Ill (Attachment #10), and Sharon Joseph, Kansas Commission on Disability Concerns (Attachment #11).

There being no other conferees, the hearing on **SB 622** was closed. The chairman announced that the bill will be blessed and assigned to a subcommittee consisting of Senators Praeger, Steffes, Hensley, Lee and Bond.

Chairman Bond announced that, in addition to **SB 757**, scheduled for hearing at tomorrow's meeting, the committee will also consider action on **SB 677**, **SB 612**, and **SB 640**.

The committee adjourned at 9:58 a.m.

The next meeting is scheduled for February 22, 1994.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE DATE: 2/21/94

NAME	ADDRESS	ORGANIZATION
Barbara Fairchild	900 SW Jackson	Ks Com on Fair HC
C. Nacke	Topeka	
M. Spencer	Topeka	Health Benefits Advisory
Terry Leatherman	Topeka	KCCI
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COM ON PUBLICATION FOR KS
Dick Brock	"	Ins Dept
ALAN COBB	WICHITA	WICHITA HOSPITALS
Don Wilson	Topeka/CR	KS Hosp. Assoc.
Rich Guthrie	KC	Health Midwest
GARY Robbins	Topeka	KS Optometric Assn
Denise Apt	Topeka	ICSA
W. Grosz	Shawnee Mission KS	Shawnee Mission Med. Ctr.
Joe Fujimoto	Topeka	KCA
Jim Schwartz	Topeka	KECH
LARRY MAGILL	"	KAIA
K. KIENM	TOPEKA	KAOM
RAY SCHER	TOPEKA	Citizen
Gena Harland	Overland Park	OP Chamber of Commerce
Robert Harder	LSOB	KDHE
Jim McBride	Topeka	observer

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kansas Hospital Association

DATE: February 10, 1994

RE: **SENATE BILL 622**

The Kansas Hospital Association appreciates the opportunity to comment in support of Senate Bill 622 and commends the legislature for continuing to move forward on those changes that are critical for health care reform. The formation of such purchasing alliances are basic to most state and national discussions of health care reform.

In theory these cooperatives give small businesses an incentive to reduce administrative costs, spread the risk characteristics of their employees and to collaborate with health plans and providers to make cost-conscious choices.

It is a basic assumption of health care reform the purchasing alliances will play a central role. For example, almost every major proposal before Congress focuses on alliances or purchasing cooperatives. President Clinton's plan would require everyone to receive health coverage through an alliance. The Cooper plan would encourage the establishment of "health plan purchasing cooperatives" through which consumers would purchase health coverage. The Chafee plan, like SB 622, would allow states to form voluntary alliances, and more than one alliance would be permitted to operate in a given geographic area. Membership in the Chafee plan alliances would be limited to employers with less than 100 employees.

We think the 100 employee provision in SB 622 is meritorious for at least three reasons. First, it is similar to the Chafee proposal, which many in Congress see as a moderate proposal that could ultimately serve as a compromise. Second, more small Kansas hospitals (72), would be able to benefit from this provision. Third, it will help move most small businesses back to community rating, which is not only a critical element of health care reform, but also of this proposal if these purchasing cooperatives are to succeed.

Senate Bill 622 is an important incremental step toward health care reform in Kansas. Small employers will now be able to take advantage of market power that until now only large employers have enjoyed. The bill also allows the state to begin reform efforts that clearly will be a part of whatever federal reform ultimately passes.

Senate FI&I 2/21/94
Attachment #1

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

According to the Kansas Department of Commerce, the following reflects business size as a percentage of the business population of Kansas.

		Number of Businesses	Total # of Businesses in Ks.
1-4 Employees	47.4%	34,703	73,237
5-9 Employees	19.6%	14,329	
10-19 Employees	11.7%	8,562	
20-49 Employees	7.6%	5,533	
50-99 Employees	2.6%	1,889	
100-249 Employees	1.6%	1,183	
250-499 Employees	.4%	267	
500-999 Employees	.14%	101	
1000+ Employees	.08%	59	

Data from March 1993

7/41 2/21/94
1-2

KANSAS
UNITS AND EMPLOYMENT
BY SIZE
MARCH 1993

NUMBER OF EMPLOYEES	EMPLOYMENT	UNITS	CUMULATIVE	
			EMPLOYMENT	UNITS
TOTAL	1,064,286	73,237		
0	0	6,611	0	6,611
1 - 4	73,089	34,703	73,089	41,314
5 - 9	94,421	14,329	167,510	55,643
10 - 19	115,099	8,562	282,609	64,205
20 - 49	167,635	5,533	450,244	69,738
50 - 99	130,219	1,889	580,463	71,627
100 - 249	177,845	1,183	758,308	72,810
250 - 499	89,765	267	848,073	73,077
500 - 999	69,608	101	917,681	73,178
1000+	146,605	59	1,064,286	73,237

KAISER PERMANENTE

TESTIMONY BEFORE THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE
S.B. 622
February 15, 1994
Cheryl Dillard
KAISER PERMANENTE
Kansas City

Mr. Chairman, and members of the Committee, I'm Cheryl Dillard, Public Affairs Manager for Kaiser Permanente in Kansas City. Kaiser Permanente is the largest and most experienced HMO in the country, with over 6.6 million members in 16 states and the District of Columbia. In the Kansas City bi-state area, we provide and finance care for over 46,000 people. We're pleased to have the opportunity to speak with you today on S.B. 622.

Senators Bond and Praeger are to be commended for introducing a package of bills aimed at reforming the health insurance market in Kansas. I have the privilege of serving on the Kansas small group reform board and Kaiser Permanente is particularly supportive of S.B. 612 which will extend the fairness market measures you passed in 1992 to many more Kansans. By expanding the definition of a small employer group from 25 employees to 50 employees, you will afford the protection of insurance market reforms and premium increase restraints to the majority of employer groups in Kansas.

S.B. 622, in amending an existing law allowing Kansas employers to band together for the purpose of purchasing insurance, attempts to encourage innovative approaches to financing and delivering health care by allowing providers to form networks and contract directly with employer alliances. We support innovation, but we encourage the Committee to consider amending S.B. 622 so that provider networks would have to obtain a certificate of authority under the Kansas HMO law.

There are two reasons to make this change. First, the Kansas HMO law affords consumers considerable protections:

- The Commissioner can define basic health services that must be available to HMO enrollees.
- HMO's are held responsible for the availability, accessibility and quality of the health care services provided.

Senate FI&I
2/21/94
Attachment #2

- HMO's must make public the names of people and organizations who are to be responsible for the conduct of its affairs.
- A grievance procedure for enrollees who are unhappy with the quality of care or service is required.
- The Commissioner has the authority to review all contracts between the HMO and its enrollees, its employer customers and the providers of its health care services.
- Finally, HMO's are held to a standard of financial responsibility for care provided within the network as well as emergency care and care provided out-of-area.

The second reason we favor the change in S.B. 622 is that, while these consumer protections are worthwhile, they require additional expenditures on the part of HMO's and those expenditures are figured into the premiums we must charge our enrollees and their employers. An HMO would be at a significant competitive disadvantage within the employer alliance if provider networks are not required to meet the same standards for solvency and consumer protection.

Kaiser Permanente strongly believes that the best health care reform will and should occur within a marketplace where the rules for all are fair and equitable. Any failures in the free market approach where consumers are harmed or provider networks are left bankrupt will seriously weaken our ability to argue against those who favor a single payor system.

7/+1 2/21/94
2-2

~~than one carrier to provide insurance.~~*:*

(1) One or more carriers to insure the risk assumed under a health benefit plan subject to any applicable deductibles, copayment or coinsurance requirements;

(2) one or more health care providers for services on behalf of its member employers and their employees, ~~but, if the health benefit plan has not been insured as permitted by subsection (a)(1) the annual gross premium for the health benefit plan shall be not less than $1,000,000; and, the alliance shall purchase and maintain specific and aggregate excess insurance provided by an insurance company holding a Kansas certificate of authority. Such specific and aggregate excess insurance shall be in effect concurrent with the assumption of risk by the alliance.~~

(b) Where appropriate, the ~~small employer~~ health benefit plan shall provide options under which eligible employees may arrange coverage for their family members. Options for additional coverage for employees and their family members at an additional cost or premium may be provided.

(c) ~~The small employer health benefit plan and~~ *An alliance or* any carrier may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. *Except as otherwise provided in this act,* the provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2,114 ~~and~~, subsection (D) of 40-2209 ~~and K.S.A.~~, 40-2229 and 40-2230~~,~~ and amendments thereto, shall not be mandatory with respect to any health benefit plan under this act.

(d) ~~The small employer health benefit plan~~ *An alliance* may impose a maximum aggregate amount on the benefits available to any covered employee or dependents from the health benefit plan provided under this act.

(e) The provisions of K.S.A. 40-2209 ~~and 40-2215~~ and amendments thereto shall apply to all contracts issued under this section ~~or the act of which this section is a part~~ and to health benefit plans ~~as defined in K.S.A. 40-2239 and amendments thereto, and the provisions of such sections~~ *and this section* shall apply to ~~small employer~~ health benefit plans. *The provisions of K.S.A. 40-2215 and amendments thereto shall apply to all insurance contracts issued under this section, and the provisions of this section shall apply to health benefit plans.*

Sec. 4. K.S.A. 40-2242 is hereby amended to read as follows: 40-2242. (a) As a condition to participation as a member of any ~~small employer health benefit plan as provided in K.S.A. 40-2240 and amendments thereto~~ *alliance*, an employer shall:

which health care providers have obtained a certificate of authority under Article 32 of Chapter 40 of Kansas Statutes Annotated.

2/21/94
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26-3

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612-2302 • (913) 233-0351

Testimony to Senate Financial Institutions and Insurance Committee

on SB 622

(Permitting small group alliances)

by James P. Schwartz Jr.
Consulting Director
February 21, 1994

I'm Jim Schwartz with the Kansas Employer Coalition on Health. The Coalition is a statewide organization of over 100 employers who share concerns about the cost-effectiveness of health care we purchase for our 300,000 employees and dependents. Almost half of our members are smaller than 100 employees and could be affected by SB 622.

Small employer purchasing alliances provide a valuable role within a "managed competition" style of health reform. SB 622 sends a signal that Kansas wants to move in that direction. My organization applauds that step -- if some problems can be overcome.

This bill offers three promises:

1) if small groups are allowed to pool their purchasing power, they can exert more price leverage on sellers of health insurance and health services;

2) that purchasing pools can achieve economies of scale in administrative expenses; and

3) that setting up an alliance structure in states allows those states to more quickly comply with future federal reforms involving alliances.

We have four concerns, though, that should be taken into account.

First, there is a threat that SB 622 could do harm to the intent of past insurance reforms, particularly SB 561. That bill required plans available to small groups to accept any

Senate FI&I
2/21/94
Attachment #3

applying group and to limit the range of prices for premiums. Those provisions are designed to spread the risk of medical costs broadly and prevent discrimination against sick or potentially sick groups. That is a bedrock principle of reform that practically everyone can agree on. SB 622 would essentially let alliances of small groups side-step that principle. Healthy groups would have a strong incentive to join "healthy alliances" that could exclude sick groups and contract directly with providers for low-risk rates.

To avoid this problem of polarizing groups according to risk, we suggest an amendment to prohibit alliances from excluding groups on the basis of health risk.

Second, there is a threat that debate on the merits of alliances could degenerate into a referendum on state mandates for coverage. My organization has historically opposed state mandates within the context of the present-day, voluntary system. We don't believe, though, that this bill is the proper vehicle for advancing that debate. Let the alliance concept prove its worth on its own merits, not on the basis of reducing coverage.

The remedy for this problem would be to hold alliances to the same coverage requirements as insured plans.

Similarly, SB 622 would give alliances special status in terms of relief from the state premium tax and from the tough solvency requirements on carriers. Such relief might be justifiable to induce uninsured groups to obtain coverage. But since such inducements have failed utterly in the past, we can predict that the only beneficiaries of SB 622 will be presently insured groups that simply want to trim costs. Again, I suggest we require alliances to earn their keep and not profit simply by avoiding taxes or taking risks that carriers may not.

Third, I'm troubled by the provision in the bill that would prohibit membership in an organization as a requirement of alliance participation. If we really want to give alliances a boost without a fiscal note, we should make it easier for existing associations to offer this service. Without such a service, small employers will struggle to find the time and expertise necessary to develop alliances.

Fourth, I'm concerned that SB 622, by using the term "alliance," will tempt the legislature and the public to believe that we have adopted "managed competition" in Kansas — and thereby have achieved meaningful reform. As defined in Congressional bills, alliances perform a host of services. Those services include report cards on health plans; cost containment; enforcing insurance reforms; enrolling the self-employed and the unemployed; and, most importantly,

HHH 2/21/94
3-2

unbundling groups so that individuals choose their health plans based on cost, quality and inclusion of favored providers. SB 622 describes a much narrower function for alliances.

Even with its modest aims, if SB 622 could rid itself of problems I've noted, it might answer an important question: whether small groups could benefit by merging their risks for purposes of health insurance. Potential savings, simply in administration, are considerable. For example, in groups smaller than five employees, only 60 cents of every premium dollar presently goes to pay for health care.

Stripped of its thorns, SB 622 could be one flower worth letting bloom. Still, I would warn against putting much hope in small group alliances as a substitute for comprehensive reform. For years, my organization has advocated reform of the health system to achieve universal coverage, reliable cost containment, incentives for quality improvement, and equity among payers. Alliances can play a valuable role in a comprehensive plan to achieve these aims, but alone they do little to advance any of them.

If we decide to give alliances a try, we should, at a minimum, make sure they do no harm to the larger goals. In particular, we should make sure that alliances' success stems from improved efficiencies in medical services and administration, rather than from shifting costs, reducing benefits or avoiding taxes.

7/4 2/21/94
3-3

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 10, 1994

TO: Senate Committee on Financial Institutions and Insurance

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 622; Concerning Small Employer Health Insurance Purchasing Alliances

The Kansas Medical Society appreciates the opportunity to express its support for SB 622. Our understanding of the intent of this bill is to provide a mechanism for small employers to join together into a health purchasing alliance, with a minimum of regulation, for the purpose of providing health coverage to their employees.

SB 622 appears to remove some regulatory barriers which prevented the law which it amends (the small employer health benefit plan act) from being utilized in the past. This proposal creates a mechanism for small employers to coalesce into a purchasing alliance free of regulations on benefit package, employer/employee contribution levels, and whether or not the employer provided health insurance previously. In short, this legislation attempts to provide the same kind of flexibility and control to groups of small employers that larger, self-insured employers currently enjoy.

We recognize that there are concerns about the issues of financial responsibility and solvency, and that some reasonable, minimum requirements may be necessary to assure that coverage is not jeopardized by financial insolvency. However, if those issues are addressed in a manner that does not put these proposed alliances out of the reach of small employers, then the concept ought to be given a chance to work.

We appreciate the opportunity to express our support for SB 622. Thank you.

JS:cb

Senate FI&I
2/21/94
Attachment #4

Testimony on SB 622
Before the Senate Financial Institutions and Insurance Committee
By: Larry W. Magill, Jr., Executive Vice President
Kansas Association of Insurance Agents
February 10, 1994

Thank you, Mr. Chairman, and members of the committee for the opportunity to appear today in support of SB 622 with amendments. Our association supports the concept of voluntary, competing alliances or HIPC's (Health Insurance Purchasing Cooperatives) as a means of providing smaller businesses with the buying clout that large firms enjoy.

However, we have serious concerns about the independent practice associations (IPA's) created by this bill under section 3, lines 41-43 and lines 5-13 on page 3. These IPA's appear to be very similar to multiple employer welfare arrangements (MEWA's) that this legislature refused to authorize several years ago because of concerns over solvency and consumer protection issues. Group self-insurance, particularly where it involves health insurance, is extremely risky. If claims reserves are not adequately set and trend factors are not accurately predicted, a MEWA or IPA could become insolvent almost before its sponsors realized it, leaving all the employers and employees to pay the claims.

In our view, the alliance or HIPC should be a nonprofit, administrative organization designed to bring the buying power of as many employers and employees together as possible to negotiate the lowest rates for its members. For that reason, the state may wish to limit the total number of HIPC's to avoid fragmenting the market and

Senate FI+I
2/21/94
Attachment #5

this buying power. Iowa, for example, limited its law to three HIPC's.

In most cases, HIPC's are envisioned to offer an insured fee for service plan, an HMO and an insured preferred provider (PPO) option.

The committee may also wish to provide some limited anti-trust exemption for the alliances to allow them to bring together competing business and health care financing systems such as fee for service, HMO and PPO under one umbrella. The Iowa legislation provides such a limited exemption.

Iowa hopes to have its first alliance up and running by July, 1994. Early indications are that California has had good success so far with an alliance there. Where, we might add, nearly 80% of the firms are being brought to the alliance by agents despite a 5% greater cost.

Attached is a balloon of the bill with suggested amendments deleting the group self-insurance option and leaving all other provisions intact. We are not aware of any states that have enacted legislation allowing alliances and also allowed them to self-insure.

We support the fact that these alliances will not be subject to Kansas health insurance mandates. This will give the employers and employees within the alliances an opportunity to design coverage that meets their needs with the maximum cost savings.

We urge the committee to adopt our amendments. As we said at the offset, we support the concept of competing, voluntary alliances and commend the sponsors for placing the concept on the table.

HHA 2/21/94
5-2

Session of 1994

SENATE BILL No. 622

By Senators Bond and Praeger

1-28

AN ACT relating to insurance; health benefit plans; amending K.S.A. 40-2239, 40-2240, 40-2241, 40-2242 and 40-2243 and repealing the existing sections; also repealing K.S.A. 40-2244, 40-2245, 40-2246 and 40-2247.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 40-2239 is hereby amended to read as follows: 40-2239. As used in this act, unless the context requires otherwise:

(a) "Carrier" means an insurance company, medical or hospital service corporation, medical and hospital service corporation or health maintenance organization which holds a valid certificate of authority from the insurance commissioner.

(b) "Commissioner" means the commissioner of insurance.

(c) "Eligible employee" means an employee who is employed by the employer ~~for an average of at least 17.5 hours per week and~~ who elects to participate in ~~one of~~ the *health* benefit ~~plans~~ *plan* provided under this act, and includes individuals who are sole proprietors, business partners and limited partners. The term "eligible employee" does not include individuals:

(1) Engaged as independent contractors;

(2) whose periods of employment are on an intermittent or irregular basis; or

(3) who have been employed by the employer for fewer than 90 days.

(d) "Family member" means an eligible employee's spouse and any unmarried dependent child or stepchild.

(e) "Health benefit plan" means a contract for group medical, surgical, hospital or any other ~~remedial~~ *health* care recognized by state law and related services and supplies.

(f) "Plan of operation" means a plan developed under K.S.A. 40-2240 and amendments thereto.

~~(f)~~ *(g)* "Premium" means the monthly or other periodic charge for a health benefit plan.

~~(g)~~ *(h)* ~~"Small employer health benefit plan"~~ *"Employer health insurance purchasing alliance" or "alliance"* means an organization of ~~small~~ employers for the purpose described in K.S.A. 40-

HB 2/21/94
5-3

2240 *and amendments thereto.*

Sec. 2. K.S.A. 40-2240 is hereby amended to read as follows: 40-2240. (a) Any two or more employers may establish ~~a small employer health benefit plan~~ *an alliance* for the purpose of providing a health benefit plan as described in ~~K.S.A. 40-2244 and 40-2245, and amendments thereto~~ *this act*, covering such employers' eligible employees and such employees' family members. ~~Small employer health benefit plan~~ *The* member employers *of each alliance* shall adopt a plan of operation providing for the selection of a board of directors and such additional provisions necessary or proper for the execution of the plan's purposes. Such plan of operation may provide for a delegation of powers and duties to a corporation, association or other organization which performs functions similar to those of the ~~small employer health benefit plan~~ *alliance*.

(b) Employers desiring to organize ~~a small employer health benefit plan~~ *an alliance* shall notify the commissioner and provide the commissioner with information on the number of employees and family members to be covered by ~~the insurance described in K.S.A. 40-2244 and 40-2245, and amendments thereto~~ *a health benefit plan*. The commissioner shall provide assistance to employers desiring to organize and maintain ~~any such benefit plan~~ *an alliance* and may aid in the acquisition of the health care insurance by the ~~small employer health benefit plan. The commissioner shall issue a certificate to every employer participating in any such small employer health benefit plan entitling such employer to claim the tax credit authorized by K.S.A. 40-2246 and amendments thereto subject to the following limitation: No certificate shall be issued to any employer seeking the same after certificates have already been issued under this act to employers offering health benefits described in K.S.A. 40-2244 and 40-2245, and amendments thereto, to an aggregate of 10,000 employees and family members entitling such employers to claim the credits for taxable years which commence after December 31, 1991, and before January 1, 1993~~ *alliance*.

Sec. 3. K.S.A. 40-2241 is hereby amended to read as follows: 40-2241. (a) ~~Any small employer health benefit plan~~ *An alliance* organized for the purposes described in K.S.A. 40-2240 and amendments thereto ~~shall be~~ *is* authorized to enter into contracts with carriers for the health care insurance ~~described in K.S.A. 40-2244 and 40-2245, and amendments thereto, or with health care providers for services~~ on behalf of its member employees. ~~A small employer health benefit plan~~ *An alliance* may contract with ~~more~~

(DELETE)

7/21 2/21/94 5-4

than ~~one carrier to provide insurance.~~:

~~(1) One or more carriers to insure the risk assumed under a health benefit plan subject to any applicable deductibles, copayment or coinsurance requirements~~; o

~~(2) one or more health care providers for services on behalf of its member employers and their employees but, if the health benefit plan has not been insured as permitted by subsection (a)(1) the annual gross premium for the health benefit plan shall be not less than $1,000,000, and, the alliance shall purchase and maintain specific and aggregate excess insurance provided by an insurance company holding a Kansas certificate of authority. Such specific and aggregate excess insurance shall be in effect concurrent with the assumption of risk by the alliance.~~ (DELETE)

(b) Where appropriate, the ~~small employer~~ health benefit plan shall provide options under which eligible employees may arrange coverage for their family members. Options for additional coverage for employees and their family members at an additional cost or premium may be provided.

(c) ~~The small employer health benefit plan and~~ *An alliance or* any carrier may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. *Except as otherwise provided in this act,* the provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2,114 ~~and~~, subsection (D) of 40-2209 ~~and K.S.A.~~, 40-2229 and 40-2230~~,~~ and amendments thereto, shall not be mandatory with respect to any health benefit plan under this act.

(d) ~~The small employer health benefit plan~~ *An alliance* may impose a maximum aggregate amount on the benefits available to any covered employee or dependents from the health benefit plan provided under this act.

(e) The provisions of K.S.A. 40-2209 ~~and 40-2215~~ and amendments thereto shall apply to all contracts issued under this section ~~or the act of which this section is a part~~ and to health benefit plans ~~as defined in K.S.A. 40-2239 and amendments thereto, and the provisions of such sections~~ *and this section* shall apply to ~~small employer~~ health benefit plans. *The provisions of K.S.A. 40-2215 and amendments thereto shall apply to all insurance contracts issued under this section, and the provisions of this section shall apply to health benefit plans.*

Sec. 4. K.S.A. 40-2242 is hereby amended to read as follows: 40-2242. (a) As a condition to participation as a member of any ~~small employer health benefit plan as provided in K.S.A. 40-2240 and amendments thereto~~ *alliance*, an employer shall:

2/21/97
5-5

(1) Employ no more than ~~50~~ *100* employees ~~who do not have health insurance as a spouse, dependent or otherwise or who are not eligible for medicaid or state medical assistance~~; *and*

~~(2) have not contributed within the preceding two years to any health insurance premium on behalf of an employee who is to be covered by the employer's contribution other than a contribution by an employer to a health insurance premium within the preceding two years solely for the benefit of the employer or the employer's dependents; and~~

~~(3)~~ (2) make a minimum contribution to be set by the board of directors of the ~~small employer health benefit plan~~ *alliance* toward the premium incurred on behalf of a covered employee.

(b) ~~The small employer health benefit plan~~ *An alliance* may terminate the participation of any employer if, for a period of three months, the employer fails to perform any action required by this act or by the plan of operation.

(c) No ~~small employer~~ health benefit plan may require membership in any association, organization or other entity as a prerequisite to membership and full participation by any employer except as specifically authorized by this act.

Sec. 5. K.S.A. 40-2243 is hereby amended to read as follows: 40-2243. ~~(a) The monthly contribution of each eligible employee for health benefit plan coverage under this act shall be the total cost per month of the benefit coverage afforded under the plan or plans, for which the employee exercises the option, including the administrative expenses therefor less the portion thereof contributed by the employer. An employee may enroll in more than one option at a time so long as such options do not offer overlapping services.~~

~~(b)~~ *(a)* ~~The employer contribution shall be the amount necessary to pay the cost of the health benefit plan covering the employer's covered employees for which the employer does not require the employee to pay, including the administrative expenses therefor.~~ An employer is not required to enroll an employee who is already enrolled in a health benefit plan other than ~~the small employer~~ *a* health benefit plan *under this act*.

~~(c)~~ *(b) When applicable,* payroll deductions for such costs payable by the employee shall be made by the employer upon receipt of a signed authorization from the employee indicating an election to participate in the small employer health benefit plan.

Sec. 6. K.S.A. 40-2239, 40-2240, 40-2241, 40-2242, 40-2243, 40-2244, 40-2245, 40-2246 and 40-2247 are hereby repealed.

2/21/94
5-6

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book.

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5-7

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STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL FOR BLUE CROSS BLUE SHIELD OF KANSAS

PRESENTED TO THE KANSAS SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE REGARDING 1994 SENATE BILL 622, FEBRUARY 15, 1994

Mr. Chairman and Members of the Committee:

I am Brad Smoot, Legislative Counsel for Blue Cross and Blue Shield of Kansas, a not-for-profit domestic mutual insurance company serving thousands of Kansans.

Thank you for this opportunity to comment on Senate Bill 622, a proposal to permit employer alliances to contract directly with providers and thereby avoid all insurance mandates and regulations.

Despite its short and simple amendments, S622 raises the most fundamental issues in the health care debate. As drafted, the bill puts the Kansas Legislature at a crossroads. By permitting small employers to bypass insurance companies and insurance laws, the bill essentially deregulates private group health insurance, the predominate source of coverage in the state.

If we are going to deregulate, we might as well go all the way. Attached is a proposed amendment listing several Kansas insurance laws, most designed for the protection of consumers, which will no longer be necessary. We offer this amendment for your consideration and as an illustration of how far-reaching S622 really is.

I would be pleased to respond to questions from the Committee.

Senate FI&I
2/21/94
Attachment #6

PROPOSED AMENDMENT TO SENATE BILL 622

New Section _____. Any insurer transacting solely the business of accident and health insurance and having more than one million dollars ($1,000,000) in annual premium, and any health maintenance organization having more than one million dollars ($1,000,000) in annual premium shall not be subject to the provisions of K.S.A. 40-208, K.S.A. 40-214, K.S.A. 40-216, K.S.A. 40-218, K.S.A. 40-221a, K.S.A. 40-225, K.S.A. 40-226, K.S.A. 40-231, K.S.A. 40-233, K.S.A. 40-234 through K.S.A. 40-234c, K.S.A. 40-235, K.S.A. 40-240 through K.S.A. 40-240g, K.S.A. 40-241 through K.S.A. 40-241k, K.S.A. 40-244, K.S.A. 40-248, K.S.A. 40-2a01 through K.S.A. 40-2a27, K.S.A. 40-2b01 through K.S.A. 40-2b28, K.S.A. 40-401, K.S.A. 40-402, K.S.A. 40-404, K.S.A. 40-404a, K.S.A. 40-405, K.S.A. 40-406, K.S.A. 40-501 through K.S.A. 40-505, K.S.A. 40-2801 through K.S.A. 40-2812, K.S.A. 40-3301 through K.S.A. 40-3315, or K.S.a. 40-3601 through K.S.A. 40-3658.

New Section _____. No insurer engaged in the business of accident and health insurance with an annual premium of at least one million dollars ($1,000,000) and no health maintenance organization with an annual premium of at least one million dollars ($1,000,000) shall be subject to the provisions of K.S.A. 40-2117 through 40-2131, K.S.A. 40-2201 through K.S.A. 40-2208, K.S.A. 40-2209a through K.S.A. 40-2209o, K.S.A. 40-2210 through K.S.A. 40-2214, K.S.A. 40-2216 through K.S.A. 40-2254, K.S.A. 40-2401 through K.S.A. 40-2421, K.S.A. 40-3001 through K.S.A. 40-3018, or K.S.A. 40-3202 through K.S.A. 40-3227, or, to the extent otherwise applicable to such an insurer's accident and health insurance business, K.S.A. 40-222 through K.S.A. 40-222f, K.S.A. 40-223 through K.S.A. 40-223g, K.S.A. 40-252 through K.S.A. 40-252e, K.S.A. 40-256, K.S.A. 40-2,100 through K.S.A. 40-2,109, or K.S.A. 40-2,111 through K.S.A. 40-2,114.

February 14, 1994

7 | 4 2/21/94
6-2

Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

Office Phone
913/233-7483

February 10, 1994

To: Senate Committee on Financial Institutions and Insurance

Re: SB 622

We request that you amend this bill by adding "or permitted" after "recognized" on page 1, line 35.

For many years, we have requested that "remedial care" be added to various health measures as it was generally understood that those words referred to Christian Science care and treatment.

Time often brings changes to definitions and word usage. We now find that, as used in this bill, health care "permitted" by the state would take care of our needs. This will clarify that the care or its providers do not have to be licensed or otherwise regulated by the state in order to be covered.

I am providing to the committee what we call our "insurance kit" which contains information which has proven useful to those interested in insurance matters. Included in the kit is a list of insurance companies which cover Christian Science care and treatment in their group policies.

Your consideration of this request is appreciated.

Keith R. Landis
Committee on Publication
for Kansas

Senate FI&I
2/21/94
Attachment #7

ASSOCIATION OF COMMUNITY
MENTAL HEALTH CENTERS OF KANSAS, INC.
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Senate Financial Institutions and Insurance
February 10, 1994

The Association of Community Mental Health Centers of Kansas provides mental health services to over 95,000 Kansas citizens. We provide services in each of the 105 counties. The centers strongly endorse most concepts of managed care and are already providing managed care to thousands of Kansans both in the public and private sector.

We generally view **S.B. 622** as a managed care approach and we endorse those efforts. However, **S.B. 622** removes/prohibits the mandates, including mental health care and treatment. We must oppose this bill. Since less than a quarter of all insurance policies written prior to the passage of the Kansas mandates had coverage for psychiatric treatment, we must assume that such a history of limited or no coverage would occur again. Therefore, we oppose **S.B. 622,** since it has the potential to eliminate coverage for the 200,000 to 300,000 who suffer from mental illness in Kansas. This is not managed care for the mentally ill, rather it will too often be no care at all.

Thank you for the opportunity to comment.

Senate FI&I
2/21/94
Attachment #8

~~than one carrier to provide insurance.~~:

(1) One or more carriers to insure the risk assumed under a health benefit plan subject to any applicable deductibles, copayment or coinsurance requirements;

(2) one or more health care providers for services on behalf of its member employers and their employees but, if the health benefit plan has not been insured as permitted by subsection (a)(1) the annual gross premium for the health benefit plan shall be not less than $1,000,000; and, the alliance shall purchase and maintain specific and aggregate excess insurance provided by an insurance company holding a Kansas certificate of authority. Such specific and aggregate excess insurance shall be in effect concurrent with the assumption of risk by the alliance.

(b) Where appropriate, the ~~small employer~~ health benefit plan shall provide options under which eligible employees may arrange coverage for their family members. Options for additional coverage for employees and their family members at an additional cost or premium may be provided.

(c) ~~The small employer health benefit plan and~~ *An alliance or* any carrier may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. *Except as otherwise provided in this act,* the provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2,114 ~~and~~, subsection (D) of 40-2209 ~~and K.S.A.~~, 40-2229 and 40-2230~~,~~ and amendments thereto, shall not be mandatory with respect to any health benefit plan under this act.

(d) ~~The small employer health benefit plan~~ *An alliance* may impose a maximum aggregate amount on the benefits available to any covered employee or dependents from the health benefit plan provided under this act.

(e) The provisions of K.S.A. 40-2209 ~~and 40-2215~~ and amendments thereto shall apply to all contracts issued under this section ~~or the act of which this section is a part~~ and to health benefit plans ~~as defined in K.S.A. 40-2239 and amendments thereto, and the provisions of such sections~~ *and this section* shall apply to ~~small employer~~ health benefit plans. *The provisions of K.S.A. 40-2215 and amendments thereto shall apply to all insurance contracts issued under this section, and the provisions of this section shall apply to health benefit plans.*

Sec. 4. K.S.A. 40-2242 is hereby amended to read as follows: 40-2242. (a) As a condition to participation as a member of any ~~small employer health benefit plan as provided in K.S.A. 40-2240 and amendments thereto~~ *alliance*, an employer shall:

Amendment requested by Chip Wheelen on behalf of Kansas Psychiatric Society

Senate 4/4/94
2/3/94
Attachment #9

Notwithstanding the provisions of K.S.A. 40-2,105 and amendments thereto, coverage for diagnosis and medically necessary treatment of mental illness shall be the same as coverage for other hospital, medical and surgical expense benefits.
[optional definition] For purposes of this act "mental illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain or disability.

40-2,105. Insurance coverage for services rendered in treatment of alcoholism, drug abuse or nervous or mental conditions; applicability or nonapplicability of section. (a) On or after the effective date of this act, every insurer which issues any individual or group policy of accident and sickness insurance providing medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must provide for reimbursement or indemnity under such individual policy or under such group policy, except as provided in subsection (d), which shall be limited to not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or nervous or mental conditions in a medical care facility licensed under the provisions of K.S.A. 65-429 and amendments thereto, a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014 and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605 and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b and amendments thereto or a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b and amendments thereto. Such individual policy or such group policy shall also provide for reimbursement or indemnity, except as provided in subsection (d), of the costs of treatment of such person for alcoholism, drug abuse and nervous or mental conditions, limited to not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 in any year and limited to not less than $7,500 in such person's lifetime, in the facilities enumerated when confinement is not necessary for the treatment or by a physician licensed or psychologist licensed to practice under the laws of the state of Kansas.

(b) For the purposes of this section "nervous or mental conditions" means disorders specified in the diagnostic and statistical manual of mental disorders, third edition, (DSM-III, 1980) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment (DSM-III, V Codes).

(c) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated.

(d) There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto.

(e) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

History: L. 1977, ch. 161, § 1; L. 1978, ch. 166, § 1; L. 1986, ch. 299, § 8; L. 1986, ch. 174, § 1; July 1.

414 2/21/94
9-2

KANSAS AMI

KANSAS ALLIANCE FOR THE MENTALLY ILL

112 S.W. 6th • P.O. Box 675
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913-233-0755 • FAX 913-233-4804

Testimony

February 10, 1994

To: Senate Financial Institutions & Insurance Committee

From: Terry Larson, Executive Director,
Kansas Alliance For The Mentally Ill

RE: The Need for Parity Coverage for Diseases of the Brain

Neuro-biological diseases of the brain continue to be discriminated against in most health insurance policies. Prior to the implementation of the mandated mental health benefits, only 22 percent of Kansans had any mental health coverage in their health insurance policies. The mandates assured people with health insurance coverages that limited mental health benefits would be provided. While this is better than nothing, the inclusion of serious mental illnesses under the mental health mandate is, in effect, highly discriminatory.

Our quest is to gain coverage equal to that of all other diseases and conditions for neuro-biological diseases of the brain. Existing mandated mental health coverages are essential; however, mental illness should not be subject to the mandated limits to mental health. Attached is a copy of "A Biological Basis for Political Advocacy" by E. Fuller Torrey, M.D. of St. Elizabeth Hospital in Washington, D.C. Dr. Torrey has been at the forefront of research of diseases of the brain, public education about mental illness and advocacy to provide better services and treatment for persons with disabling mental illnesses.

Whether Kansas continues with existing coverages, seeks incremental changes to broaden access or makes sweeping changes to promote universal access, the discrimination by insurance companies against mental illnesses must stop. At least under the mandates, for example, a maximum of 30-day in-patient services are allowed. Again, this is better than nothing. On the other hand, there is no 30-day maximum placed on chemotherapy for cancer or other serious physical conditions.

Efforts to enhance health insurance access by small employers is laudable. But mental illness can randomly strike any employee of any business, regardless of size.

Thanks

Senate FI+I
2/21/94
Attachment #10

NAMI Leadership Conference
February 6, 1994

A Biological Basis for Political Advocacy

E. Fuller Torrey, M.D.

Question Should all "mental illnesses" be covered at parity with physical illnesses under a national health plan? NAMI has said "yes" and has advocated for this in coalition with a broad range of other mental health organizations.

Facts

1. A just published study funded by NIMH interviewed 8,098 people to ascertain the incidence of 14 different "serious" mental disorders. The results were widely reported in the media, e.g. "1 in 2 found to suffer mental disorder," (New York Times January 14, 1994). The study found that 30 percent of Americans suffer from one of these 14 disorders during any given year.

2. Census figures from 1990 show that there are 218 million Americans over the age of 10.

- 218 million x 30% = 65,400,000 people with a "serious" mental disorder in any given year.
- Under the proposed Clinton plan each of them is eligible for 30 outpatient visits per year. At an average of $80 per outpatient visit, that is 65.4 million people x 30 outpatient visits x $80 per visit or $157 **billion** per year if all people eligible for benefits utilized all benefits. And this does not even include inpatient, case management, or rehabilitation costs.
- To give perspective to this figure, $157 billion is 63 times more than all U.S. foreign aid ($2.5 billion), 21 times more than the entire NIH budget ($7.4 billion), almost 4 times more than the entire federal Medicaid budget ($40.7 billion), and equivalent to 71 percent of the federal deficit ($220 billion).
- Is it any wonder that the National Association of Manufacturers and other business interests oppose the proposed mental health benefits under the Clinton plan?

Proposal

We should advocate for equal coverage for only those mental disorders for which evidence exists that they are primarily biological in nature. These diseases are brain diseases and thus should be on exactly the same footing as multiple sclerosis, Parkinson's disease, Alzheimer's disease, etc. We should expect equal coverage for all diseases of the brain -- no more but no less.

The mental disorders for which I believe there is clear and convincing evidence of being brain diseases include the following:

- schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, and atypical psychosis
- major affective disorders (bipolar and major depression), cyclothymic disorder and dysthymic disorders
- obsessive compulsive disorder
- panic disorder

7+1 2/21/94

10-2

- agoraphobia
- childhood onset pervasive developmental disorder (including autism)
- childhood attention deficit disorder
- anorexia nervosa and bulimia
- mental retardation
- dementia

Having a genetic component or genetic predisposition should not by itself qualify a disorder as a brain disease. There are genetic components to most personality characteristics (e.g. outgoingness) and skills (e.g. mathematical or musical ability). Therefore just because alcohol and drug abuse have a genetic component would not qualify them as brain diseases. Furthermore, there is a volitional, self-responsibility component to these disorders which differentiate them from all of those listed above. Under the criteria proposed, therefore, substance abuse as a primary diagnosis should not be covered by a national health plan.

What Should Be Done?

- NAMI should lobby for parity coverage of brain diseases on a biologi... basis. This would mean dropping out of the broader "mental health" coalitions and alienating organizations such as the American Psychiatric Association and American Psychological Association.
- State AMIs should advocate for similar coverage in state plans which are rapidly evolving and for insurance laws along these lines.

Conclusions

- There is no hope whatever that "all" mental disorders can be covered under a national health plan. It is time to recognize that fact and plan accordingly.
- Working in coalition with other "mental health" organizations on this issue has gotten us nowhere.
- Therefore it is time to work for equal coverage of serious mental illnesses which are known to be brain diseases.
- We should do this as the leader of the mental illness lobby, not as part of a "mental health" lobby.

4/4 2/21/94
10-3

KANSAS COMMISSION ON DISABILITY CONCERNS
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TESTIMONY PRESENTED TO SENATE FINANCIAL INSTITUTIONS AND INSURANCE

by

Sharon Joseph, Chairperson
February 10, 1994

Senate Bill 622

Mr. Chair, members of the committee, thank you for this opportunity to testify today on Senate Bill 622.

Kansas Commission on Disability Concerns advocates for the rights of all people with disabilities. Your proposal to amend Sec. 4 K.S.A. 40-2242(a)(1) on page 4, line 1 would allow employers with up to 100 employees to participate in the "alliance". According to figures supplied by Kansas Department of Human Resources Labor Market Information Services (see attached Table 1), employers with between 1 and 99 employees represent 97.58% of all employers in the State of Kansas. The current law exempts those employers enrolled in the Small Employer Health Benefit Plan from numerous insurance mandates. Exempting employers with under 100 employees from the mandates will leave over half of the labor force in this state, along with their families, without the guarantee of at least the basic coverage for things such as treatment for mental conditions and services performed by a Licensed Social Worker.

KCDC advocates for equality in all health care benefits. We promote health care coverage that does not in any way treat one type of disability different than others. Exempting employers from the mandated coverage of treatment for mental conditions promulgates the long-standing myth that people with mental illness are of a "lesser breed" and not worthy of equal treatment under the laws of this state. We would like to see a health care plan that does not distinguish between mental and physical disability, thus eliminating the need for mandates such as those contained in K.S.A. 40-2,105.

Senate FIAI 2/21/94
Attachment #11

TABLE 1
NUMBER OF FIRMS AND EMPLOYEES
COVERED BY THE KANSAS EMPLOYMENT SECURITY LAW
FIRST QUARTER 1993 1/

employment size class	number of firms 1/	number of employees	cumm firms	cumm percent firms	cumm employees	cumm percent employees
Totals	66,626	1,064,286				
1-4	34,703	73,089	34,703	52.09%	73,089	6.87%
5-9	14,329	94,421	49,032	73.59%	167,510	15.74%
10-19	8,562	115,099	57,594	86.44%	282,609	26.55%
20-49	5,533	167,635	63,127	94.75%	450,244	42.30%
50-99	1,889	130,219	65,016	97.58%	580,463	54.54%
100-249	1,183	177,845	66,199	99.36%	758,308	71.25%
250-499	267	89,765	66,466	99.76%	848,073	79.68%
500-999	101	69,608	66,567	99.91%	917,681	86.23%
1000 and over	59	146,605	66,626	100.00%	1,064,286	100.00%

1/ AN ADDITIONAL 6611 FIRMS REPORTED ZERO EMPLOYEES

LABOR MARKET INFORMATION SERVICES
KANSAS DEPARTMENT of HUMAN RESOURCES
401 TOPEKA AVE.
TOPEKA, KANSAS 66603
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4+1 2/21/94

11-2