Approved February 14, 1990
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague at
Chairperson

3:30 xx a.m./p.m. on February 12, 19 90 in room 531-n of the Capitol.

All members were present except:
Representative Henry Helgerson, excused
Representative Larry Turnquist, excused

Committee staff present: Chris Courtwright, Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

see attached list

The meeting was called to order at 3:40 p.m.

Representative Littlejohn made a motion to approve the minutes of February 6, February 7 and February 8, 1990. Representative Turnbaugh seconded. The motion carried.

The Committee continued topic briefings on Mandated Health Insurance Coverages.

Dick Brock, Insurance Department provided testimony (Attachment 1)expressing the Departments views that mandated benefits inhibit the flexibility of benefit design and add to the cost of health insurance. Mr. Brock included a legislative suggestion which attempts to enhance flexibility of benefit design by eliminating the mandate that requires groups to buy the statutorily prescribed coverages but assures availability by providing that such benefit must be provided if requested by the policyholder.

Bill Pitsenberger, Blue Cross/Blue Shield presented testimony (Attachment 2) addressing the costs, equity and structural problems sometimes associated with mandated benefits.

Terry Leatherman, Kansas Chamber of Commerce and Industry (KCCI) provided surveys (Attachment 3) of its members on their insurance experience which included their opinion on repealing mandated insurance benefits.

Next appearing was Jim Schwartz, Kansas Employer Coalition on Health (KECH). Mr. Schwartz provided a position statement (Attachment 4) prepared by a subcommittee of the KCCH which constitutes a comprehensive approach to restructuring the health care financing and delivery systems on a state or federal level.

Walt Whalen, Pyramid Life provided testimony (Attachment 5) explaining the various factors that contribute to the cost of health care insurance and the effect mandated benefits have upon these costs.

Meyer Goldman, Kansas HMO Association provided testimony (Attachment 6) which expressed that the establishment of mandates contribute substantially to the escalating costs of health care delivery. Mr. Goldman explained that each added mandate works against improvement in benefits available to consumers, raising the costs beyond the ability to pay and encouraging employers to switch to less desirable health care delivery systems that avoid the mandates. Mr. Goldman also provided a document (Attachment 7) produced by the International Foundation of Employee Benefit Plans' presentation of Federal and State-Mandated Benefits.

Next testifying on behalf of Catholic Health Association was John Holmgren. Mr. Holmgren provided testimony (Attachment 8) expressing the view that mandated benefits protect people employed and covered by health insurance programs from catastrophic financial loss.

Terry McGeeny, Saint Joseph Medical Center, Wichita, KS provided testimony (Attachment 9) which explained the ACCESS Employee Assistance Program and its assistance offered to chemically dependent persons and their families.

Larry Mannion, Saint Joseph Medical Center, Wichita, KS provided testimony (Attachment 10) expressing the importance of mandated benefits for chemically dependent persons. Mr. Mannion explained its costs effectiveness by stating that an employer who limits or eliminates coverage for chemical dependency treatment will pay substantially more to treat the diseases which are the result of untreated chemical dependency.

Howard Snyder, Kansas Alliance for the Mentally Ill (AMI), provided testimony (Attachment 11) strongly advocating the continuation of mandated benefits.

Other conferees wishing to testify were asked to return for tomorrow's meeting due to the time.

The meeting was adjourned at 5:30 p.m.

GUEST LIST

COMMITTEE: _____ DATE: 2/12

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Dick Brock	Topeka	Jus Dept
Terry McGeeney	Wichita	St Joseph Medical Center
L.M. Cornish	Topeka	Ks Life Ins. Assn.
Willard C. Spencer, MD	Topeka	Kansas Radiologic Soc.
Joseph S. Kun	Topeka	BC/BS of Kansas
Fred Palenske	Topeka	BC/BS of Kansas
Larry Mannion	Wichita	St Joseph Med. Ctr.
John H. Hoamgren	Topeka	Catholic Health Corp
Jane McGeeney	Wichita	
Patrick M. Mooney	Wichita	
Tom Gress	Topeka	KS Hosp. Assn.
Terry Leatherman	Topeka	KCCI
Bryce Miller	Topeka	MHAK
Ruth Sullivan	"	MHAK
Lou & Howard Snyder	Prairie Village	Kansas AMI
Tom Keller	Topeka	SRS/ADAS
Alan Cobb	Wichita	KRCS
Jack Roberts	Topeka	BC-BS
W.F. Pitsenberger	Topeka	BCBS
Meyer L. Goodman	Kansas City	Prime Health
Ken Baker	Topeka	Charter Hospital
[signature]	Topeka	MHRS/SRS
Sara DeCourcey	Topeka	KS Psychological Assn.
Jim Oliver	"	PsA
Cheryl Dillard	Kansas City	Kaiser Permanente
Terry Larson	Topeka	Ks AMI

GUEST LIST

COMMITTEE: ____________________ DATE: ____________

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Gigi Felix MSW	Topeka	K-NASW
John Peterson	Topeka	

Kansas Insurance Department
Testimony Before the
House Insurance Committee
on Kansas Mandated Health Insurance Coverages
Presented by Dick Brock

As I indicated during the joint House/Senate Committee hearing on health insurance, no discussion of current health insurance concerns would be complete without some thought being given to mandated benefits. There is no question but what mandated benefits inhibit the flexibility of benefit design and there is little, if any, question that they add to the cost of health insurance. Much of this additional cost is a result of increased use of the health care services for which insurance coverage is mandated. Whether this increased utilization results in a public good that offsets the public cost is, of course, a core question. But, regardless of the answer to that question, we cannot deny the increased health insurance cost.

While I only summarized my comments for the joint committee, more detail is contained in my written testimony and rather than repeat it here, I will simply refer you to it.

I do want to point out, however, that one other portion of my joint committee testimony bears a significant relationship to the cost/benefit dilemma posed by mandated benefits. Again, I will not repeat it but I will remind you that Kansas statutes do not -- and I am aware of no other state's statutes -- that require the establishment of a statistical reporting system which would accumulate a credible body of data to, among other things, measure or provide an opportunity to measure the impact of such influences as mandated benefits on health insurance costs. That is not a timely subject for our discussion today but it is a practical example of how a uniform statistical plan for accident and sickness insurance could add to our knowledge.

Attachment 1

As you, of course, know, there are other bills currently before this session of the legislature which deal with mandated benefits. One adds a mandate, one expands the application of an existing mandate and one would require proponents of mandates to conduct and present a cost/benefit analysis on what a given proposal might or might not do. While not introduced and not included in the Department's legislative proposals, the Department also prepared a legislative suggestion prior to the convening of this session which deals with mandates. I have attached a copy of this suggestion to my testimony. This suggestion starts with the premise that the current and increasing level of health care costs and health insurance premiums demands maximum flexibility in benefit design if people are to be able to utilize their health care dollars in the most appropriate and efficient way. We always need to remember that mandated health insurance benefits not only require insurance companies to provide something, they also require accident and sickness insurance purchasers to buy something. Therefore, statutorily mandated benefits obviously do not conform to any notion of flexibility in benefit design. On the other hand, there are some benefits that might not be available to a particular group without some kind of statutory requirement. Thus, the unavailability of desired benefits can also have an adverse effect on flexibility but probably to a lesser degree than the mandated inclusion of benefits. Accordingly, this proposal attempts to enhance flexibility of benefit design by eliminating the mandate that requires groups to buy the statutorily prescribed coverages but assures availability by providing that such benefits must be provided if requested by the policyholder.

This approach does require complete elimination of the mandated benefits for individual policies because adverse selection simply makes the required availability provision impossible. However, until we develop some means of addressing the availability problem in general so that

people who are completely uninsurable or have an uninsurable condition can have some means available of financing their health care, the possible inability to buy coverage that will duplicate the benefits now mandated by statute should be a reduced priority.

You will note that this suggestion does not suggest a change in the current continuation and conversion law which is often and properly so included in considerations involving mandated benefits. Any change in the Kansas continuation requirements would have minimal impact because of the federal requirements. But, even more important, is the fact that the original reasons for enacting the continuation and conversion requirements are just as and even more valid than they were at the time of enactment. This does not mean particular provisions cannot be modified to improve the general ability of the statutes to do what they need to do in a more cost efficient way but we have not looked at this possibility. As a matter of fact, any effort or review of this kind should probably be considered separately and should not be combined with any broad study of mandated benefits generally.

Finally, I want to emphasize that the legislative proposal attached to my testimony is a discussion draft only. It may have some technical or grammatical flaws but the concept is, I hope, apparent.

LEGISLATIVE PROPOSAL NO. 4

AN ACT relating to insurance; accident and sickness insurance; mandated benefits; amending K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,114 as amended by 1989 Senate Bill No. 98, K.S.A. 1988 Supp. 40-2230 and repealing the existing sections.

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

Section 1. K.S.A. 40-2,100 is hereby amended to read as follows: 40-2,100. Notwithstanding any provision of any ~~individual,~~ group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the healing arts act of this state, reimbursement or indemnification under such policy, contract, plan or agreement shall, if requested by the policyholder and upon payment of any appropriate premium charge, not be denied when such services are performed by an optometrist, dentist or podiatrist acting within the lawful scope of their license.

Sec. 2. K.S.A. 40-2,101 is hereby amended to read as follows: 40-2,101. Notwithstanding any provision of any ~~individual,~~ group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the Kansas healing arts act, reimbursement or indemnification under such policy contract, plan or agreement shall, if requested by the policyholder and upon payment of any appropriate premium charge, not be denied when such service is rendered by any such licensed practitioner within the lawful scope of his license.

Sec. 3. K.S.A. 40-2,102 is hereby amended to read as follows: 40-2,102. All ~~individual and~~ group health insurance policies providing coverage on an expense incurred bases and ~~individual and~~ group service or indemnity type contracts issued by a profit or nonprofit corporation which provides coverage for a family member of the insured or subscriber shall, if requested by the policyholder as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one day period.

Sec. 4. K.S.A. 40-2,103 as amended by 1989 Senate Bill No. 98 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102 ~~and~~ , and 40-2,114 and amendments thereto shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state when the coverage or benefits resulting from application of such requirements is provided.

Sec. 5. K.S.A. 40-2,104 is hereby amended to read as follows: 40-2,104. Notwithstanding any provision of ~~an individual or~~ a group policy or contract of health and accident insurance, delivered within the state whenever such policy or contract shall provide for reimbursement for any service within the lawful scope of practice of a duly licensed psychologist within the state of Kansas, the insured, or any other person covered by the policy or contract shall, if requested by the policyholder, be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or a duly licensed psychologist.

Sec. 6. K.S.A. 40-2,105 is hereby amended to read as follows: 40-2,105. (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~~ shall, if requested by the policyholder, 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 alcoholic 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.

Sec. 7. K.S.A. 40-2,114 as amended by 1989 Senate Bill No. 98 is hereby amended to read as follows: 40-2,114. Notwithstanding any provision of ~~an individual or~~ any group policy or contract of health and accident insurance, delivered within the state, whenever such policy or contract shall provide for reimbursement for any service within the lawful scope of practice of a duly licensed specialist social worker authorized to engage in private, independent practice under subsection (a) of K.S.A. 75-5353 and amendments thereto within the state of Kansas, the insured or any other person covered by the policy or contract shall, if requested by the policyholder, be allowed and entitled to reimbursement for such service unless subject coverage in those insurance plans in existence on or before March 15, 1989, is refused in writing by the policyholder prior to March 15, 1989, irrespective of whether it was provided or performed by a duly licensed physician or a duly licensed specialist social worker authorized to engage in private, independent practice under subsection (a) of K.S.A. 75-5353 and amendments thereto.

Sec. 8. K.S.A. 1988 Supp. 40-2230 is hereby amended to read as follows: 40-2230. Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this act applies, whenever reimbursement or indemnity for laboratory or x-ray services are covered, reimbursement or indemnification shall, if requested by the policyholder, not be denied for mammograms or pap smears performed at the direction of a person licensed to practice medicine and surgery by the board of healing arts within the lawful scope of such person's license. A policy, provision, contract, plan or agreement may apply to mammograms or pap smears the same deductibles, coinsurance and other limitations as apply to other covered services.

Sec. 9. K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,114 as amended by 1989 Senate Bill No. 98 and K.S.A. 1988 Supp. 40-2230 are hereby repealed.

Sec. 10. This act shall take effect and be in force from and after its publication in the statute book.

HOUSE INSURANCE COMMITTEE
HEALTH INSURANCE FACTS HEARINGS
MANDATED INSURANCE BENEFITS
February 12, 1990

Mandated benefits -- specifying what must be covered, or what kinds of providers must be covered -- under insurance policies is a relatively recent development in health insurance regulation. Prior to 1973, statutes regulating health insurance were largely procedural in nature -- how one made a claim under a health insurance policy, what defenses an insurer could assert, and so forth. Beyond that, what services were covered, and what providers of services were covered, was largely a matter of what the marketplace offered and demanded.

The first state mandated benefit statute in Kansas became effective July 1, 1973, and required that whenever a service was covered under a health insurance policy when performed by an M.D., it must also be covered when performed by a dentist, podiatrist, optometrist, or any person licensed by the Board of Healing Arts, i.e., osteopaths and chiropractors.

Effective July 1, 1974, health insurance contracts were required to provide benefits from the moment of birth for a child born under a family policy. This addressed a practice common in commercial insurers, but in which Blue Cross never engaged, of not making benefits available until 15 days or 30 days after birth in order to avoid the extreme expense potential some ill newborns present.

Also in 1974, health insurers were required to provide benefits for services of a certified psychologist if the service would be covered if performed by an M.D. That is, if an insurer would pay for psychotherapy by a psychiatrist, then the insurer also had to pay for psychotherapy by a psychologist. This law did not require, however, coverage of psychotherapy.

Obligations to cover services for nervous and mental conditions, drug abuse and alcoholism have had an extensive and complicated history. Initially, the law required that unless refused in writing, group health insurance policies had to cover such services under specific levels of coverage:

- 30 days of coverage when services are received by an inpatient in a hospital, community mental health center, or drug abuse or alcohol treatment facility.

- $1,000 of benefits for treatment rendered on an outpatient basis by such facilities or by an M.D. or psychologist.

Attachment 2

More recently, that law was changed to require coverage at those levels in all individual and group insurance policies, rather than making them optional on a group basis only.

A law related to that law, in some ways, require that unless refused in writing, insurers pay for services of licensed specialists clinical social workers (LSCSW's) if they would pay for the same services performed by an M.D. In essence, since a contract had to include coverage for $1,000 in outpatient nervous and mental benefits, a contract would have to pay as well for those benefits if provided by an LSCSW unless LSCSW coverage was refused in writing. This was changed last year to delete the optional nature -- to do away with the ability to refuse the coverage for LSCSW's.

Two years ago, the legislature enacted a law which required insurance companies to pay for mammographies and pap smears.

Other state laws may not be so readily identified as mandated benefit laws. One such law is the one which requires insurance companies to provide six months continuation of group coverage when coverage would be otherwise lost, and to provide a conversion contract at the end of those six months. Some examples of when this applies include:

- When one's spouse in a group dies or is terminated from employment.

- When a child reaches an age limit for dependents.

- When a group changes carriers, or goes to self-insurance and the new carrier or self-insurance plan refuses to cover someone, because of past health conditions, for example.

- When a group dissolves -- goes out of business, ceases to provide insurance, or goes bankrupt.

Another, reverse mandate, is the Insurance Department regulation which prohibits subrogation in health insurance policies.

Mandates are obviously adopted because someone believes there to be a problem in the health insurance mechanism serious enough to require an expression of public policy on the matter through enactment of the law.

One observation I would have about that is that those laws which mandate coverage of specific providers of service -- chiropractors, psychologists, and social workers -- and at least some of the laws mandating coverage of specific services -- here

I am thinking of coverage of nervous and mental conditions, drug abuse and alcoholism -- have invariably been requested, and lobbied for, by those providers who would benefit from the laws, not by the insureds or the employer groups purchasing the coverage. That is, such laws seem to the insurance community to be merely attempts to "tap in" to the third-party payment mechanism, rather than an attempt to cure any pressing social problem.

Other mandated benefits, however, are difficult to argue with. The concept of not covering newborn children is one difficult for me personally to understand, and Blue Cross has always provided such coverage.

Besides motivational questions, mandated benefits raise serious policy questions the legislature should carefully consider.

The first is the "ERISA" problem. ERISA is the Employee Retirement Income Security Act of 1974. Among its provisions is one which states, in essence, that a self-insured employee benefit program may not be regulated by state insurance laws. Simply as a financial matter, an employer must be fairly large in order to self-insure, so that one or two very big claims do not ruin it financially. Most large employers in Kansas and in other states are self-insured; one study we once had of Wichita suggested that as many as 35% of persons in Sedgwick County were covered by self-insurance programs which Blue Cross did not administer, and others were covered by self-insurance programs administered by Blue Cross. Of the ten largest employers in Shawnee County, most, except the State, are self-insured.

Because self-insurers are not subject to mandated benefit laws, the attempt to express social policy through mandates of benefits is an ineffectual promise to many of your constituents. Worse, the burden of mandated benefits falls largely on those who apparently have the biggest problems in acquiring health coverage, small businesses.

Unevenness of application, then, is the major problem of mandated benefits.

I might note that mandated benefit proposals spark some interesting discussions at Blue Cross. Since the burden falls equally on us and our competitors in the insurance market, whether we are obligated to pay for the service of, for example, social workers should not matter to us. Since we also administer self-insured plans, even those who escape mandates by self-insurers are not lost to us in the market sense.

Rather than being an insurance company issue or an issue for providers of health care services, then, mandated benefits are more properly a consumer issue. Unfortunately, you tend to see a lot of lobbyists for health care providers on these bills, Blue Cross and Blue Shield, and sometimes a spokesman for health insurance companies, but almost never those whose welfare and rights you are addressing in these laws.

That brings me to the other big issue in mandated benefits, costs. Although you sometimes hear a provider group telling you that requiring coverage for their services will reduce the cost of health care as a whole -- for example, the argument that paying for a social worker to treat alcoholism will reduce total health care costs because (a) social workers tend to charge less than psychiatrists, and (b) treating alcoholism reduces consequential diseases such as liver damage and heart problems -- it is almost never true in at least the short run.

We have passed out what we have identified as some mandated benefit costs to Blue Cross in 1988. You might want to follow through that with me.

We didn't identify on there the costs of prohibiting subrogation, which we think is about one-half of 1% of total claims.

In addition to problems of inequity in application and of cost, there are structural problems in some of the mandated benefits. For example, the law requiring coverage of 30 days of inpatient treatment of substance abuse is interpreted to require that these services be treated the same as services for all other conditions. This means that an insurer is generally obligated to pay for not only the modestly priced services of a Valley Hope and the moderately priced services of most acute care hospitals alcoholism treatment programs but also the expensive costs of for profit hospitals specializing in this kind of treatment.

Some people argue that it is wasteful to obligate an insurer to pay, for example, $25,000 for 30 days of inpatient psychiatric or substance abuse treatment per year, but limit benefits for outpatient treatment of those conditions to $1,000 per year and $7,500 for a lifetime, since outpatient treatment is (they say) more cost effective.

Our mammography mandate may be unique among states, allowing for unlimited mammographies; most states which have such mandates cover a baseline mammography, one every few years thereafter, and one a year in the critical years for breast cancer.

In closing, I would note that there are several bills dealing with mandated benefits around these halls this year. Senate Bill 431 in the Senate Judiciary Committee, dealing with the Kansas Adoption Act, would require insurance contracts to pay for the delivery expense of birth mothers and to provide coverage for adopted children from the moment of birth, two subjects which this Committee heard about in separate bills last year. Senate Bill 633, in the Senate FI & I Committee, would require insurance policies to pay for the services of an advanced registered nurse practitioner.

Representatives Wells and Hoy of this Committee have introduced two bills of interest, House Bill 2888 and House Bill 2889. 2888 would require an impact statement before a mandated benefits bill could be considered. 2889 changes most mandated benefit laws into an optional offering of coverage. Finally, Senate Bill 396 provides that a subrogation provision may be included in health insurance policies.

Blue Cross and Blue Shield of Kansas

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

Claims Cost to Blue Cross and Blue Shield Subscribers
1988

State Mandates		Overall Dollars	Per Contract Single	Per Contract Family	Comments
A. Chiropractors (7/1/73)	BS	$5,679,618	$0.67	$4.17	Coverage became effective 7/1/73.
B. Dentists (7/1/73)	*BS	1,196,395	0.29	0.75	Dentist services already covered under Blue Shield same as M.D. prior to being mandated.
C. Optometrists (7/1/73)	BS	2,299,330	0.13	1.81	Eye exams had been covered by M.D.'s under Major Medical prior to being mandated.
D. Podiatrists (7/1/73)	*BS	757,821	0.12	0.53	Podiatrists services already covered under Blue Shield same as M.D.'s prior to being mandated.
E. Newborn Infants (Ill Baby Care) (7/1/74)	*BS	598,122	----	0.50	Service was already covered prior to being mandated.
	*BC	1,214,450	----	0.98	
	Total	1,812,572		1.48	
F. Psychologists (Direct Reimbursement) (7/1/74)	*BS (This expense is included in overall Psy. Outpatient Expense on Line I)				Service covered (if billed by M.D.) prior to being mandated.

* Benefit covered prior to being mandated.

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

Claims Cost to Blue Cross and Blue Shield Subscribers
1988

State Mandates		Overall Dollars	Per Contract Single	Per Contract Family	Comments
H. Inpatient Nervous and Mental, Chronic Alcoholism, and Drug Addiction covered same as for any other condition.	1. First 30 Days *BC *BS (covered same as daily round)	$ 8,944,790 5,976,294	$ 2.61 1.63	$ 5.02 3.59	House Bill 2737 requires the offering of the first 30 days of in-patient care limited to same as a daily round.
I. Outpatient Psychiatric Services	Basic rider HB #2737	$4,925,245	$1.62	$ 2.72	House Bill #2737 requires the addition of $1,000 maximum Psychiatric Outpatient Services for all contracts.
J. Mammography and Pap Smear coverage without X-ray and Lab Riders. (HB #2229)	* BS	1,736,204	0.79	0.77	Coverage of mammography and pap smear services under basic policy.
K. Licensed clinical Social Workers billing without physician's referral	* BS	(This expense is included in overall Outpatient Psy. Expense on Line K)			Effective 7/1/82 Licensed Clinical Social Workers no longer need physician's referral to bill direct.
Grand Total State enacted mandated coverage		$33,329.270	$7.86	$20.84	

*Benefit covered prior to being mandated.

Exhibit A
(Local Mandate)

1988 BLUE SHIELD CHIROPRACTOR

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1987 Incurred As Paid Thru 12-31-88 Single	1987 Incurred As Paid Thru 12-31-88 Family	Unpaid Factors	Estimated Incurred Single	Estimated Incurred Family
Basic	$ 72,744.75	$ 346,553.15	1.123	$ 81,692.35	$ 389,179.19
X-Ray	16,200.20	48,953.40	1.123	18,192.82	54,974.67
Lab	339.93	1,899.25	1.123	381.74	2,132.86
Supplemental Accident	539.40	2,269.00	1.123	605.75	2,548.09
Miscellaneous	3,984.00	24,538.20	1.123	4,474.03	27,556.40
Major Medical	179,337.40	393,525.67	1.360	243,898.86	535,194.91
Large First-Dollar and Shared Payments Major Medical	1,239,832.93	3,098,888.99	1.191	1,476,641.02	3,690,776.79
National Joint Major Medical	20,211.59	1,311,849.82	1.194	24,132.64	1,566,348.69
MER and Disabled	38,773.75	----	1.129	43,775.56	----
Total	$1,571,963.95	$5,228,477.48		$1,893,794.77	$6,268,711.60

	Si	Fa
1. 1988 Contract Months (All Comp. and NonComp.)	2,833,968	1,502,550
2. 1988 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)	$ 0.67	$ 4.17
3. 1988 NonComplementary Contract Months (Less Nat'l Participating Accts.)	1,031,768	1,196,243
4. 1988 Estimated Mandated Costs	$ 691,285	$ 4,988,333

Exhibit B
(Local Mandates)

Mandated Coverages (Dentists)

		Single	Family
1.	1988 rates for full prevailing Blue Shield plus out-patient X-ray	$28.16	$73.10
2.	Percent of rate applicable to dental coverage (from special study)	1.03%	1.03%
3.	Monthly rate applicable to dental coverage under basic (Line 1 x Line 2)	0.290	0.753
4.	Rounded 1988 pure premium for basic dental	$ 0.29	$ 0.75

Exhibit C
(Local Mandates)

1988 BLUE SHIELD OPTOMETRISTS

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1988 Incurred As Paid Thru 12-31-88 Single	1988 Incurred As Paid Thru 12-31-88 Family	Unpaid Factors	Estimated Incurred Single	Estimated Incurred Family
Basic	$ 2,132.09	$ 13,478.74	1.123	$ 2,394.34	$ 15,136.63
X-Ray	796.00	777.70	1.123	894.00	873.36
Lab	68.25	16.00	1.123	76.64	17.97
Supplemental Accident	---	---	1.123	---	---
Miscellaneous*	23,700.73	121,315.44	1.123	26,615.92	136,237.24
Major Medical Rider	28,715.41	102,191.87	1.360	39,052.96	138,980.94
First-Dollar Major Medical	240,372.19	647,747.70	1.191	286,283.28	771,467.51
National Joint Major Medical	2,072.27	1,393,394.27	1.194	2,474.29	1,663,712.76
Plan 65 and Disabled	15,804.28	---	1.029	17,843.03	---
Total	$313,661.22	$2,278,921.72		$375,634.46	$2,726,426.41

	Si	Fa
1. 1988 Contract Months (All Compl. and NonCompl.)	2,833,968	1,502,550
2. 1988 Estimated Pure Premium	$ 0.13	$ 1.81
3. 1988 Noncomplementary Contract Months	1,031,768	1,196,243
4. 1988 Estimated Mandated Costs	$ 134,130	$ 2,165,200

Exhibit D
(Local Mandates)

1988 BLUE SHIELD PODIATRISTS

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1988 Incurred As Paid Thru 12-31-88 Single	1988 Incurred As Paid Thru 12-31-88 Family	Unpaid Factors	Estimated Incurred Single	Estimated Incurred Family
Basic	$ 47,045.85	$ 89,600.40	1.123	$ 52,832.49	$100,621.25
X-Ray	7,082.20	15,821.10	1.123	7,953.31	17,767.10
Lab	88.00	807.75	1.123	98.82	907.10
Supplemental Accident	---	100.00	1.123	---	112.30
Miscellaneous*	9,146.43	13,836.86	1.123	10,271.44	15,538.79
Major Medical	9,548.52	14,048.86	1.360	12,985.99	19,106.45
Large First-Dollar Major Medical	200,620.95	338,439.95	1.191	238,939.55	403,081.98
National Joint Major Medical	1.302/82	204,483.59	1.194	1,662,91	244,153.41
Plan 65, MER, Disabled	11,859.87	---	1.129	13,389.79	---
Total	$286,784.54	$677,138.51		$338,134.30	$801,288.38

	Si	Fa
1. 1988 Contract Months (All Compl. and NonCompl.)	2,833,968	1,502,550
2. 1988 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)	$ 0.12	$ 0.53
3. 1988 Noncomplementary Contract Months (Less National Participating Accts.)	1,031,768	1,196,243
4. 1988 Estimated Mandated Costs	$ 123,812	$ 634,009

Exhibit D
(Local Mandates)

1988 BLUE SHIELD PODIATRISTS

Rate Evaluation
(Includes State Employee Group)

Type Benefit	1988 Incurred As Paid Thru 12-31-88 Single	Family	Unpaid Factors	Estimated Incurred Single	Family
Basic	$ 47,045.85	$ 89,600.40	1.123	$ 52,832.49	$100,621.25
X-Ray	7,082.20	15,821.10	1.123	7,953.31	17,767.10
Lab	88.00	807.75	1.123	98.82	907.10
Supplemental Accident	---	100.00	1.123	---	112.30
Miscellaneous*	9,146.43	13,836.86	1.123	10,271.44	15,538.79
Major Medical	9,548.52	14,048.86	1.360	12,985.99	19,106.45
Large First-Dollar Major Medical	200,620.95	338,439.95	1.191	238,939.55	403,081.98
National Joint Major Medical	1.302/82	204,483.59	1.194	1,662,91	244,153.41
Plan 65, MER, Disabled	11,859.87	---	1.129	13,389.79	---
Total	$286,784.54	$677,138.51		$338,134.30	$801,288.38

	Si	Fa
1. 1988 Contract Months (All Compl. and NonCompl.)	2,833,968	1,502,550
2. 1988 Estimated Pure Premium (Total estimated Incurred ÷ Contract Months)	$ 0.12	$ 0.53
3. 1988 Noncomplementary Contract Months (Less National Participating Accts.)	1,031,768	1,196,243
4. 1988 Estimated Mandated Costs	$ 123,812	$ 634,009

Exhibit E
(Local Mandates)

Mandated Coverages (Newborn Infants - Ill Baby Care)

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

A. Blue Cross costs projected to 1988 = $0.98

B. Blue Shield costs projected to 1988 = $0.50

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

Exhibit F
(Local Mandates)

Mandated Coverages (Psychologists)

		SingleFamily
1.	Estimated 1988 cost to pay UCR benefits to psychologists versus statewide average under the basic psychiatric rider; based on special study.	$0.52 $0.81

This expense is included in overall outpatient psychiatric expense on Exhibit I.

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

		Single	Family
Blue Cross			
1.	Projected Blue Cross claims expense per contract month for 30 days nervous and mental, drug addiction, and chronic alcoholism (from special nervous and mental study)	$2.61	$5.02
2.	Projected Blue Cross claims expense per contract month for 60 days at full payment plus 60 days at 50% payment for nervous and mental, drug addiction and chronic alcoholism (from special nervous and mental study)	3.18	6.10
3.	Extension of days from 30 to 120 for Blue Cross (Line #2 - Line #1)	0.57	1.08
4.	Percent 30 days nervous and mental, chronic alcoholism and drug addiction expense is of 120 days nervous and mental, chronic alcoholism and drug addiction (Based on 120 days paid at 100%)	75.8%	75.9%
Blue Shield			
5.	Estimated additional Blue Shield claims expense for 60 days at full payment plus 60 days at 50% payment for nervous and mental, chronic alcoholism and drug addiction based on projected claims expense of 1988 filed rate	$2.15	$4.73
6.	Estimated 1988 Blue Shield expense for 30 nervous and mental, chronic alcoholism and drug addiction visits limited to range maximum for medical visits. Assumes percent to decrease visits from 120 to 30 in Blue Shield is equal to Blue Cross decrease in days (Line #4 X Line #5)	1.63	3.59
7.	Extension of days from 30 to 120 for Blue Shield (Line #5 - Line #6)	0.52	1.14
8.	Psychiatric charges above daily round for 30 days based on 1988 filed rate	0.72	1.61
9.	Psychiatric charges above daily round for 30 to 120 days based on 1988 filed rate	0.24	0.51

Blue Cross and Blue Shield of Kansas
State Mandated Health Coverage in Kansas
Previously Enacted, Proposed Now, Possible for Future
Claims Cost to Blue Cross and Blue Shield Subscribers
1988

Federal Mandates			Overall Dollars	Per Contract Single	Per Contract Family	Comments
A. Obstetrical Benefits on Single Contracts	*	BS	$2,094,489	$2.03	$----	This coverage has been available on an optional basis and rates have been approved and filed with the Insurance Department. The offering of this benefit was mandated for groups of 15 or more during 1979.
	*	BC	2,515,107	2.41	----	
		Total	4,609,596	4.44	----	
B. Remove OB Waiting Periods		BS	2,625,010	0.55	1.72	The offering of this benefit, along with single OB coverage, was mandated for groups of 15 or more during 1979.
		BC	3,947,326	0.79	2.52	
		Total	6,572,336	1.34	4.24	
C. COBRA Legislation for Veteran and Military coverage		Total	$1,560,000	0.43	0.70	Blue Cross - Blue Shield coverage became primary carrier over Federal coverage.
D. Chronic Renal Disease Coverage for 1st 12 Months		BC	511,992	0.29	----	Coverage effective 10/1/81 for over age 64. Previously covered for under age 65 subscribers.
		BS	134,640	0.08	----	
		Total	646,632	0.37	----	
E. TEFRA - standard group coverage (excluding Medicare) for employed persons over age 65		BC	2,627,412	79.45		Coverage effective 9/1/83 for employe age 65 to 69.
		BS	2,675,032	80.89		
		Total	5,302,444	0.84	2.94	
Noncomplementary				$ 7.05	$7.88	
Complementary				0.37	----	
Grand Total Federally Enacted Mandated Coverage			18,691,008			

* Benefit covered prior to being mandated.

Exhibit A
(Federal Mandates)

Mandated Coverages (Obstetrical Benefits on Single Contracts)

Cost for full coverage as filed with the Insurance Department:

		1988*
Blue Cross	=	$2.41
Blue Shield	=	$2.03

*With waiting period.

Exhibit B
(Federal Mandate)

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

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

	Single	Family*
Blue Cross	$0.79	$2.52
Blue Shield	$0.55	$1.72

*(all covered females including dependent daughter.)

Exhibit C
(Federal Mandate)

Mandated Coverages (Primary Coverage for Veterans and Military)

1.	Average National cost provided by actuary at National Blue Cross and Blue Shield	$195,000,000
2.	Kansas' percent of national population (less Johnson and Wyandotte counties)	0.8%
3.	Estimated costs for Kansas veterans and military (Line #1 X Line #2)	$1,560,000

Exhibit D
(Federal Mandate)

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

		Blue Cross	Blue Shield
1.	Estimated new dialysis patients during a 12 month period	37	37
2.	% of population enrolled under Blue Cross and Blue Shield (under age 65)	33.3%	33.3%
3.	Potential Blue Cross and Blue Shield subscribers with renal disease in first 12 months of treatment (Line #1 X Line #2)	12	12
4.	Estimated annual charge for hospital maintenance dialysis	$42,666	$11,220
5.	Total charge to Blue Cross and Blue Shield for dialysis (Line #3 X Line #4)	$511,992	$134,640
6.	Cost per contract when total cost is spread over all supplementary contracts	$0.29	$0.08

Exhibit E
(Federal Mandate)

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

		Blue Cross	Blue Shield
1.	Current average rate for coverage of employees under age 65	$52.97	$ 53.93
2.	% increase in rate for persons over age 65 (provided by consulting actuary)	250%	250%
3.	Estimated average rate for employees over age 65 (Line #1 X Line #2)	$132.42	$134.82
4.	Additional cost per contract month (Line #3 - Line #1)	$79.45	$ 80.89
5.	Contract months for 1988	33,070	33,070
6.	Estimated 1988 additional costs (Line #5 X Line #4)	$2,627,411.50	$2,675,032.30

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 Bank IV 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

February 12, 1990

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Insurance Committee

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

I am Terry Leatherman with the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to address the issue of mandated benefit requirements in health care insurance.

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.

To prepare for this issue, KCCI is surveying its members on their insurance experiences, including their opinion on repealing mandated insurance benefits. The survey

asks members if they offer health care insurance to workers, if premium rates have changed in the past year, if they have adopted any cost saving measures, their opinion on the repeal of mandated benefits and whether they would continue some mandated benefits in a voluntary system. Here are a few overall impressions from the survey results.

*** We were hoping at least 100 members would complete and return their surveys. As of Friday, 350 had been returned with more pouring in today. We feel this response demonstrates our members' concerns about this issue.

*** Health insurance costs are soaring in Kansas. 93% of respondents are paying more this year for insurance than last year. More than 50% are paying 20% or more in premium increases.

*** 92% of surveyed businesses offer health insurance programs to workers, which is higher than national averages. However, a breakdown by business size shows 100% of large employers offer health insurance, compared to 77% of small businesses. This is consistent with national studies and shows small businesses have a tougher time finding insurance coverage.

The next five pages detail the KCCI survey results.

KCCI HEALTH CARE INSURANCE SURVEY

Business size: total results Businesses surveyed: 350 (10[illegible]

1. Does your business offer a health care insurance program to employees and dependents?

	YES		NO	
	321	92 %	29	8 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	38	11 %
increased 10% to 20%	95	29 %
increased 20% or more	176	53 %
decreased	1	.3 %
stayed the same	22	7 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	185	53 %
employee contributions	141	40 %
eligibility period	25	7 %
changed insurance co.	87	25 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
203	58 %	93	27 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an optometrist, chiropractor or podiatrist	144	41 %
Services by a duly licensed psychologist	167	48 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	205	59 %
Mammograms or pap smears laboratory testing	226	65 %

If so, on what payment basis?

Employer/employee share	190	73 %
Employer pays	29	11 %
Employee pays	43	16 %

KCCI HEALTH CARE INSURANCE SURVEY

Business size: 10 or less employees Businesses surveyed: 71 (20%)

1. Does your business offer a health care insurance program to employees and dependents?

	YES		NO	
	55	77 %	16	23 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	6	10 %
increased 10% to 20%	19	32 %
increased 20% or more	29	48 %
decreased	0	0 %
stayed the same	6	10 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	28	39 %
employee contributions	6	8 %
eligibility period	1	1 %
changed insurance co.	11	15 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
36	51 %	24	34 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an opto-metrist, chiropractor or podiatrist	27	38 %
Services by a duly licensed psychologist	27	38 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	34	48 %
Mammograms or pap smears laboratory testing	35	49 %

If so, on what payment basis?

Employer/employee share	30	64 %
Employer pays	7	15 %
Employee pays	10	21 %

KCCI HEALTH CARE INSURANCE SURVEY

iness size: 10 to 25 employees Businesses surveyed: 86 (25%

1. Does your business offer a health care insurance program to employees and dependents?

	YES		NO	
	78	91 %	8	9 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	7	9 %
increased 10% to 20%	19	24 %
increased 20% or more	50	62 %
decreased	0	0 %
stayed the same	5	7 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	45	52 %
employee contributions	30	35 %
eligibility period	4	5 %
changed insurance co.	20	23 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
53	62 %	23	27 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an optometrist, chiropractor or podiatrist	32	37 %
Services by a duly licensed psychologist	34	40 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	45	52 %
Mammograms or pap smears laboratory testing	52	60 %

If so, on what payment basis?

Employer/employee share	36	59 %
Employer pays	12	20 %
Employee pays	13	21 %

KCCI HEALTH CARE INSURANCE SURVEY

iness size: 25 to 100 employees Businesses surveyed: 114 (3

1. Does your business offer a health care insurance program to employees and dependents?

	YES		NO	
	109	96 %	5	4 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	12	11 %
increased 10% to 20%	31	28 %
increased 20% or more	64	57 %
decreased	1	1 %
stayed the same	4	4 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	68	60 %
employee contributions	56	49 %
eligibility period	10	9 %
changed insurance co.	37	32 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
66	58 %	32	28 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an opto-metrist, chiropractor or podiatrist	45	39 %
Services by a duly licensed psychologist	54	47 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	68	60 %
Mammograms or pap smears laboratory testing	81	71 %

If so, on what payment basis?

Employer/employee share	69	78 %
Employer pays	6	7 %
Employee pays	13	15 %

KCCI HEALTH CARE INSURANCE SURVEY

iness size: more than 100 employees Businesses surveyed: 79 (23

1. Does your business offer a health care insurance program to employees and dependents?

YES		NO	
79	100 %	0	0 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	13	16 %
increased 10% to 20%	26	33 %
increased 20% or more	33	42 %
decreased	0	0 %
stayed the same	7	9 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	44	56 %
employee contributions	49	62 %
eligibility period	10	13 %
changed insurance co.	19	24 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
48	61 %	14	18 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an optometrist, chiropractor or podiatrist	40	51 %
Services by a duly licensed psychologist	52	66 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	58	73 %
Mammograms or pap smears laboratory testing	58	73 %

If so, on what payment basis?

Employer/employee share	55	83 %
Employer pays	4	6 %
Employee pays	7	11 %

The issue before this committee today is the effects mandated insurance benefits have on the Kansas insurance marketplace. Working with the assumption that mandated benefits do contribute to higher insurance costs, here are some final conclusions from our survey.

1. Increasing premium costs are hitting businesses of all sizes hard. However, small businesses are the ones that are canceling insurance programs. They are also the businesses most affected by mandated coverages, because self-insurance is seldom an option for the small businessman or woman.

2. Business is exhausting conventional methods of insurance cost control. New solutions are needed to halt soaring price increases.

3. The survey question on voluntarily offering current mandated benefits is very revealing. The larger the business size, the more likely the mandated benefit would be offered in a voluntary system.

This indicates eliminating mandated benefits could bring a very desired result. More small businesses would offer their employees basic health insurance. Meanwhile, a majority of larger employers will continue to offer mandated coverages in their employee insurance packages. In the end, the marketplace will determine the true need for the current mandated coverages.

As I mentioned earlier, this survey is not complete. In fact, our deadline for members to return their surveys is this Friday. While I am confident our final results will be very similar to the current totals, I would be happy to submit those final results to this committee, as soon as they are compiled.

Once again, thank you for the opportunity to address this critical issue, and I would be happy to attempt to answer any questions.

Discussion Draft #4

KANSAS EMPLOYER COALITION ON HEALTH, INC. PROPOSAL FOR COMPREHENSIVE IMPROVEMENTS TO THE HEALTHCARE FINANCING AND DELIVERY SYSTEMS

February, 1990

Abstract:

A sub-committee of the Kansas Employer Coalition on Health has prepared recommendations for alleviating the problems of rising cost, inequitable access, and variable quality, which are endemic to the present healthcare funding and delivery systems throughout the United States, including Kansas. The recommendations constitute a comprehensive approach to restructuring the system on a state or federal level, yet build on existing institutions and systems to a large extent.

The primary components of the proposal are requirements for 1) universal health insurance coverage through employer-based plans and a publicly sponsored plan, 2) regulation of insurance rate increases by a formula closely tracking the CPI, 3) required uniformity of premium rates within each plan (community rating), 4) required acceptance by insurance plans of any applying employer group, 5) quality monitoring and support for medical research into preferred methods of treatment (protocols), and 6) reform of the medical malpractice laws.

Attachment 4

Background

The present methods of funding and delivering healthcare in Kansas (and throughout most of the United States) have allowed or contributed to the emergence of several serious problems:

1) Healthcare costs have increased at an alarming rate throughout the 1980's, far outstripping the overall inflation rate and doubling approximately every five years.

2) An estimated 500,000 Kansans (over 30 million Americans) are without any insurance against the cost of medical care, a condition that leads to uncompensated services by providers and an undesirable level of cost-shifting to paying patients.

3) Morbidity and mortality statistics for the United States are unenviable compared to those of other developed countries, despite this country's leading role in healthcare spending.

The urgency behind efforts to solve these problems is nowhere as evident as in the case of cost inflation. Even under optimistic assumptions about attenuation of the current trends, cost projections for the year 2000 appear prohibitive. If current trends are projected, future costs will be truly staggering.

	Average Annual Insurance Inflation Rate				
	10%	15%	20%	25%	30%
Year					
1990	$400	$400	$400	$400	$400
'91	440	460	480	500	520
'92	484	529	576	625	676
'93	532	608	691	781	879
'94	586	700	829	977	1,142
'95	644	805	995	1,221	1,485
'96	709	925	1,194	1,526	1,931
'97	779	1,064	1,433	1,907	2,510
'98	857	1,224	1,720	2,384	3,263
'99	943	1,407	2,064	2,980	4,242
2000	$1,037	$1,618	$2,477	$3,725	$5,514

Effect of Health Insurance Inflation Factors on Family Policy Rates

Healthcare observers generally agree that market forces of the 1980's have failed to deal successfully and permanently with these problems. In response, members of the KECH Governmental Affairs Committee created a subcommittee to seek other long-term solutions to the problems.

The Long-Term Solutions Subcommittee was constituted in April, 1989, represented by two member each from business, insurance, and providers (with assistance from KECH staff).

The group began by identifying the major problems facing healthcare purchasers today. The problems of cost, access, quality and demand were explored in considerable detail. Particular attention was placed on the question of why supply/demand economic forces had failed to control healthcare costs. Many answers to that question emerged, including 1) separation of payer and vendor by virtue of insurance, 2) ability of some patients to receive treatment without paying, 3) provider-created demand for services (providers influence the amount of care dispensed), 4) commonplace attitudes among patients that only the best care is acceptable and that more care is better care, 5) lack of usable data for consumers on prices and quality of services, 6) a lack of rational consumerism on the part of sick and frightened patients, and 7) consumers often view the system as being responsible for curing them and do not accept responsibility for their lifestyles and health.

Why have competitive forces failed to control costs?

- separation of payer and vendor by virtue of insurance;
- ability of some patients to receive treatment without paying;
- provider-created demand for services (providers influence the amount of care dispensed);
- commonplace attitudes among patients that only the best care is acceptable and that more care is better care;
- lack of usable data for consumers on prices and quality of services;
- a lack of rational consumerism on the part of sick and frightened patients;
- consumers' view of the system as being responsible for curing them, without accepting responsibility for their lifestyles and health.

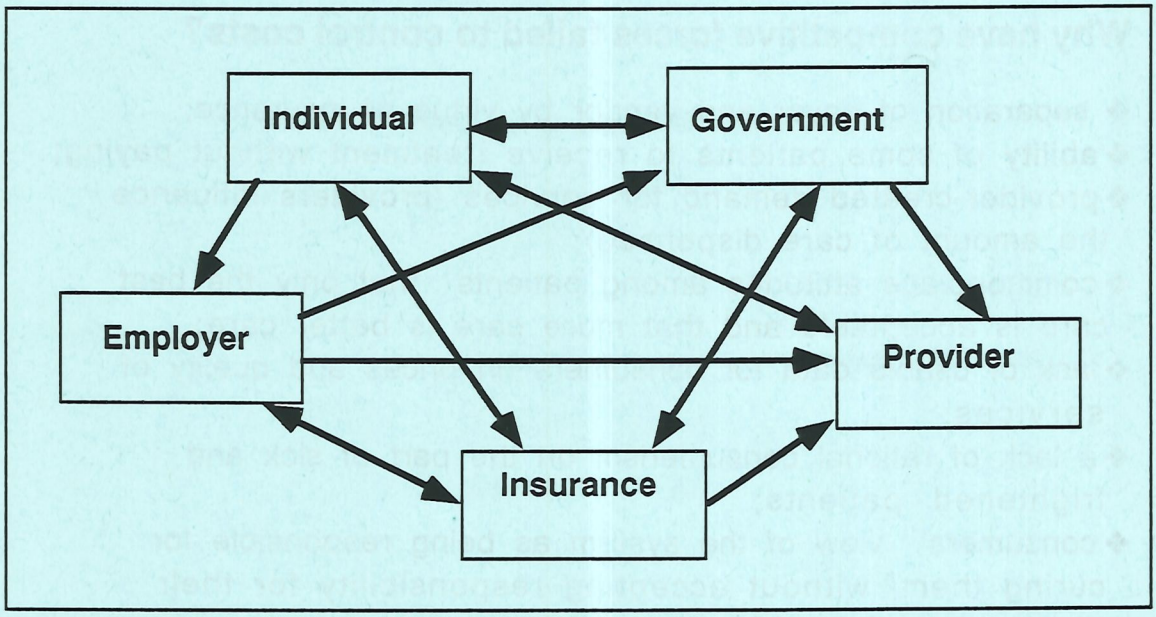
The group explored domestic proposals for reform, as well as a number of foreign systems: Canadian, western European and Pacific rim. Because of cultural differences between these countries and the United States, none of these systems appeared directly applicable to this country.

A consensus emerged within the group that the problems of cost, access and quality are interrelated. Further, the group came to view the prospects for long-term solutions as more favorable within the context of a comprehensive restructuring of the system; simply expanding the current system and amplifying present cost-containment techniques would likely prove inadequate. The

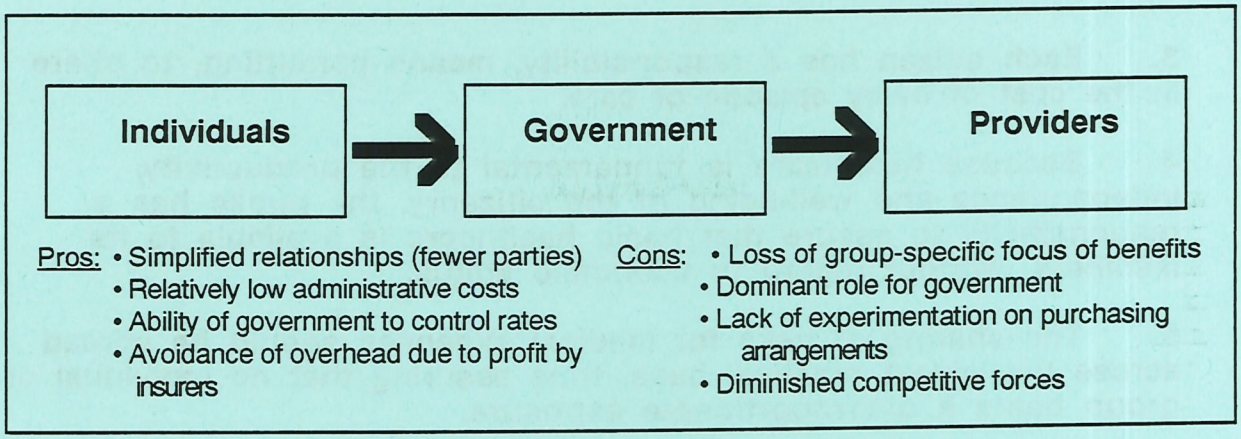
committee felt that a comprehensive reform could succeed on a state level but that a national initiative would be preferable because such an approach might deal better with the problems of conflicting federal laws and multi-state logistics.

Agreement was reached that lasting solutions must include making difficult choices. Those choices must be based on funding priorities for competing societal needs, including housing, education, defense, transportation, and retirement security, to name only a few. Given that funding available for healthcare is finite, some rational method must be devised to assure that healthcare resources are applied so as to render the best possible health outcomes for the dollar—for the citizenry as a whole. Such a choice carries with it the result that not all possible services will be funded; services of marginal value would have to be sacrificed in favor of those that give more benefit for the expense.

The committee recognized that the funding relationships in the present system carry a heavy burden of administrative complexity. In addition, the diffusion of purchasing authority detracts from clout necessary to control costs.



Flow of funds in the "pluralistic" US healthcare system



Flow of Funds in a Typical Single-Payer Health Insurance System

The group came to recognize that a healthcare system involving a single payer has advantages in terms of administrative streamlining and clout for controlling costs. At the same time, it was acknowledged that since the single payer would likely be government, any proposal for such a system would have to contend with a deep skepticism in U.S. society about government's ability to operate such a sensitive system.

Determined to begin with an approach that minimizes the role of government and yet achieves reform of the system, the committee agreed that an evolutionary approach—building on existing foundations—is desirable, possible and, in all likelihood, politically necessary. The goal became to envision new relationships among existing players such that 1) competitive forces operate to trim and energize the system and 2) governmental activities are limited to the issuance of a few simple rules.

If, however, reform such as that proposed here, retaining multiple payers, fails to contain costs, then a single-payer system involving a stronger governmental role will likely be required.

After many months of discussion, the group concurred on a set of principles on which to base action. Those principles, tempered by recognition of some political realities, societal constraints, and a spirit of give and take, led to the formation of a set of recommendations for restructuring the state or national healthcare funding and delivery systems.

Principles

1. Each citizen or citizen's family has a responsibility to secure financial protection against major healthcare costs and so should participate in a comprehensive plan of health insurance.

2. Each citizen has a responsibility, means permitting, to share in the cost of his or her insurance plan.

3. Each citizen has a responsibility, means permitting, to share in the cost of every episode of care.

4. Because healthcare is fundamental to the productivity, independence and well-being of the citizenry, the public has a responsibility to assure that basic healthcare is available to its members, without regard to economic status.

5. The sharing of risks for medical expenses should be spread across the widest practical base, thus assuring that no individual or group bears a disproportionate exposure.

6. Proposals for system reform should build upon current structures to a maximum extent consistent with achieving control of costs, access and quality.

7. Proposals for system reform should minimize reliance on regulatory controls, consistent with goals for costs, access and quality.

Recommendations and Rationale

1) Require each citizen to subscribe to a broad plan of health insurance coverage.

The group concluded after much debate that healthcare is perceived by the American public as fundamental to the productivity, independence, and well-being of the citizenry. In order to secure such a basic good, the public has a responsibility to assure that a reasonable level of healthcare is available to all its members, without regard to economic status. Committee members who doubted the responsibility of society to individuals in this regard still tended to concede the value to society of providing basic treatment in order to prevent expensive emergency care.

With these precepts in mind, the committee agreed that a key tenant of the proposal is to require each citizen to subscribe to a broad plan of health insurance coverage.

At first the committee wanted to limit the scope of required coverage to some narrow, "basic" range of services. Then, however, the group came to realize that whatever cost-containment strategy was employed, it could succeed only to the extent that the health plan has breadth. Failing to make the coverage broad simply invites continued escalation of costs for uncovered services.

With that premise in mind, the committee agreed that the required breadth of coverage should be similar to that of the HMO Act or Medicare.

Notwithstanding serious reservations about the appropriateness and utility of having employers sponsor health plans, the group felt that an evolutionary approach to achieving universal coverage would likely start with existing employer-insurance relationships. Under the committee's recommended approach, employers would have the option to either provide coverage or pay a tax to help support a publicly sponsored plan.

Individuals would be required to help support their plan participation through either premium sharing (in the case of employer-sponsored plans) or taxation (in the case of the publicly sponsored plan). Currently, many uninsured individuals are those who could afford to contribute to the cost of insurance. When they incur major medical expenses, their expenses must be shifted to the insured population. Thus by requiring individual participation in the cost of insurance, costs would more equitably be spread among those who are able to bear them. Moreover, a requirement for individual premium sharing would make patients more cognizant of costs and, presumably, wiser purchasers of care.

Detailed funding schemes that satisfy these requirements have been articulated by the National Leadership Commission on Health Care[1] and Enthoven [2].

The publicly sponsored plan could be managed directly by the state (or federal government) or indirectly through fiscal intermediaries who would bid for contracts. State Medicaid programs could be folded into the public plan.

Taxes on individuals for the publicly sponsored plan would reflect income (and perhaps asset) level, probably with some realistic cap on taxable amount.

The committee expects that market forces will maintain a strong commitment by employers to providing coverage. Those forces include the need to attract labor by offering a contribution to insurance premiums and tax deductibility of those contributions. In addition, employers would be free to offer private, supplemental insurance for conditions not covered in the basic plan.

2) Require the state (or the federal government) to determine a single maximum annual percentage of premium increase (or taxation increase in the case of the publicly sponsored plan) for all H.I. plans.

The committee agreed that the concept of a budget is fundamental to healthcare cost containment. An expeditious way to achieve a budget without inviting government to assign roles and apportion resources would be to require the state (or the federal government) to determine a single maximum annual

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[1] *For the Health of a Nation.* National Leadership Commission on Health Care. Health Administration Press, a Division of the Foundation of the American College of Healthcare Executives. January 1989.

[2] *A Consumer-Choice Health Plan for the 1990's.* Alain Enthoven and Richard Kronick. New England Journal of Medicine, Vol. 320, No. 1, 1989.

percentage of premium increase (or taxation increase in the case of the publicly sponsored plan) for all H.I. plans.

The rate adjustment would be determined by a formula closely tracking the Consumer Price Index. The reason for not limiting the increases strictly to the CPI is that some latitude may be needed 1) to fund general medical research and research on protocols (see item #3, below), 2) for funding improved technology, and 3) to reflect changes in the injury/illness patterns of society. A separate pool made up of all carriers could be created to fund widespread catastrophes or unpredictable epidemics.

This requirement for limiting increases in insurance rates effectively establishes a budget for the system. Experience has taught that when the healthcare system is constrained in a particular direction, it tends to bulge out in another direction. Thus the group felt that only through establishing a budget for the entire system could expansion of the system be controlled.

The effect of limiting rate increases would be to place insurers at risk for increasing costs. Thus insurers would have a powerful incentive to control costs. The committee believes that a natural reaction by insurers would be to form tightly integrated managed-care alliances with providers in order to share the financial risk with those providers. Careful cost/benefit judgements would be required of insurers and their provider allies in determining such matters as capital expansion, preference among treatment locations and modalities, length of confinement, and selection of materials and subcontractors. Providers who fail to help the plan stay within budget would be less attractive to plan sponsors.

The committee expects that such rate regulation would probably force a consolidation of the health insurance industry from the hundreds now licensed in Kansas to those that can develop the capability to manage costs. Indeed, insurers may eventually become the financing and marketing arms of the delivery system.

All of these changes are desirable from the standpoint of reducing the administrative overhead associated with the present fragmented system. In addition, this strategy creates incentives to apply provider compensation methods that reward cost-effective behavior. For example, fee-for-service plans would be expected to give way to plans that pay providers by salary, per patient or per case. Where fees are paid, fee schedules and expenditure targets would be employed.

A politically attractive aspect of this strategy is that desirable economic changes are encouraged simply by limiting the pot of funds available for care. The market will then attend to realignment, without need for sweeping government intervention.

3) Quality of healthcare services will be assured through government monitoring and establishment of publicly sponsored research on medical protocols.

When cost containment is discussed, providers often warn about the possibility that quality will suffer. The committee is sensitive to pressures for diminished quality when financing is limited. Thus the committee affirms its belief that providers should be accountable for an acceptable level of quality. To guard against deteriorating quality, the committee recommends that government monitor quality of medical services and make reports available to the public. In addition, a portion of the taxes on employers, insurers and individuals should be earmarked for research on medical protocols. The reason for this last item is that there is wide variation in practice styles, unsupported by evidence of differing effectiveness or outcomes. Research on protocols would help clarify some of the "gray areas" in medicine and raise some of the "art" to the level of science.

4) Require insurers to community-rate their groups.

The health insurance industry began with the concept that costs should be spread among many people, so that no individual would risk financial devastation from health care expenses. Early insurance plans charged the same rate for all groups within a given community. This practice became known as "community rating."

Eventually some groups discovered that through good fortune their members were unusually healthy and so needed less care than those of other groups. They found carriers who would rate them according to their exceptionally low-cost experience. Having lost these low-cost members, the original plans quickly found their costs per beneficiary much higher and so needed to raise premiums.

This trend of splitting the healthy from the unhealthy has continued until the cost of insurance for some less-healthy groups has become unaffordable. Even seemingly innocuous practices such as rating groups by age and sex may effectively shift costs toward the most needy. The offering of multiple options within groups has further aggravated this situation. Worse yet, some groups have resorted to questionable practices like excluding seriously ill members from the plan to keep costs in line.

If one accepts the premise that the public has a responsibility to assure it members a reasonable level of care, regardless of economic status, then it follows that systemic reform must restore the practice of well people shouldering the financial burden imposed on the ill and aged. Experience rating, by contrast, tends to shift costs to the ill, injured and aging — often the people least able to cope with such demands. Thus the committee includes in its proposal a requirement for community rating, meaning a single set of rates based only on dependent status and the broadest practical geographic basis.

To fully realize the system-wide benefits of community rating, the ability of individual companies to splinter off from the community and pay only for preferred risks would have to be minimized. Thus it is recommended that self-insured plans be gradually phased out. The potential long-run costs of self-

insurance under the current system are likely to be much greater than the long-run costs associated with participation in a community-rated plan with costs controlled as outlined in this proposal.

The committee recognized that any weakening of the concepts of experience rating or self-insurance would tend to reduce savings to the insurance plan attributable to corporate health promotion. Several countervailing arguments are in order here. First, the record of direct savings to health plans stemming from corporate health promotion programs suggests that savings are difficult to measure and are usually modest. Many consultants suggest operating such programs not for their potential savings to the insurance plan but for improved productivity, attendance and morale. Second, the high turnover rate in many industries limits the ability of health promotion programs to reap rewards for the sponsoring firm. This situation arises because the benefits to health promotion on health status are generally slow to manifest. The long-term nature of health promotion argues instead for community rating, coupled with public health education, so that improvements to health status would apply to the plan despite turnover in employment.

After weighing these trade-offs, the committee concurred that the net advantages of a strategy that includes community rating, taken as a whole, outweigh the loss of savings through health promotion by isolated plans.

In order to stabilize community-rated pools, a "shock claim" or "catastrophic claim" pool could be sponsored by all insurers in the community. This fund would ensure that major claims are spread over the widest possible base.

5) Require insurers to quote and accept any employer group or association of employer groups that applies, within capacity limits.

Some groups presently encounter an extreme form of experience rating: not by premium levels, but by exclusion at any price. There is currently much financial pressure on insurers to "skim" the healthiest risks from the available population. Thus it is commonplace for insurers to refuse to write coverage for groups with high claims histories—or to cancel groups that develop such records. The effect of such practices is to segregate the ill from the able, which benefits the able at the expense of the unfortunate. For the same reasons presented for recommendation #4 above, the committee recommends that insurers be required to accept any employer-based group (or association of employer groups) that applies.

6) Require each patient or patient's family, means permitting, to pay some fee for every episode of care, up to some out-of-pocket maximum.

The group felt that efforts to contain the overall costs of healthcare must address demand by individuals. The first Rand Corporation study showed that medical services perceived as "free" tend to be utilized at a greater rate than those that bear some cost to the recipient. Many current insurance plans pay all or nearly

all of the cost of treatment. Others share costs primarily through deductibles, which are often removed in time (and thus in mind) from the act of requesting services.

7) Require ancillary activities by government.

To provide a context for reform, government should provide leadership to develop healthcare policy -- on a national, regional and state level.

Since prevention is the best medicine and education is the key to prevention, government should provide improved health education services to the public.

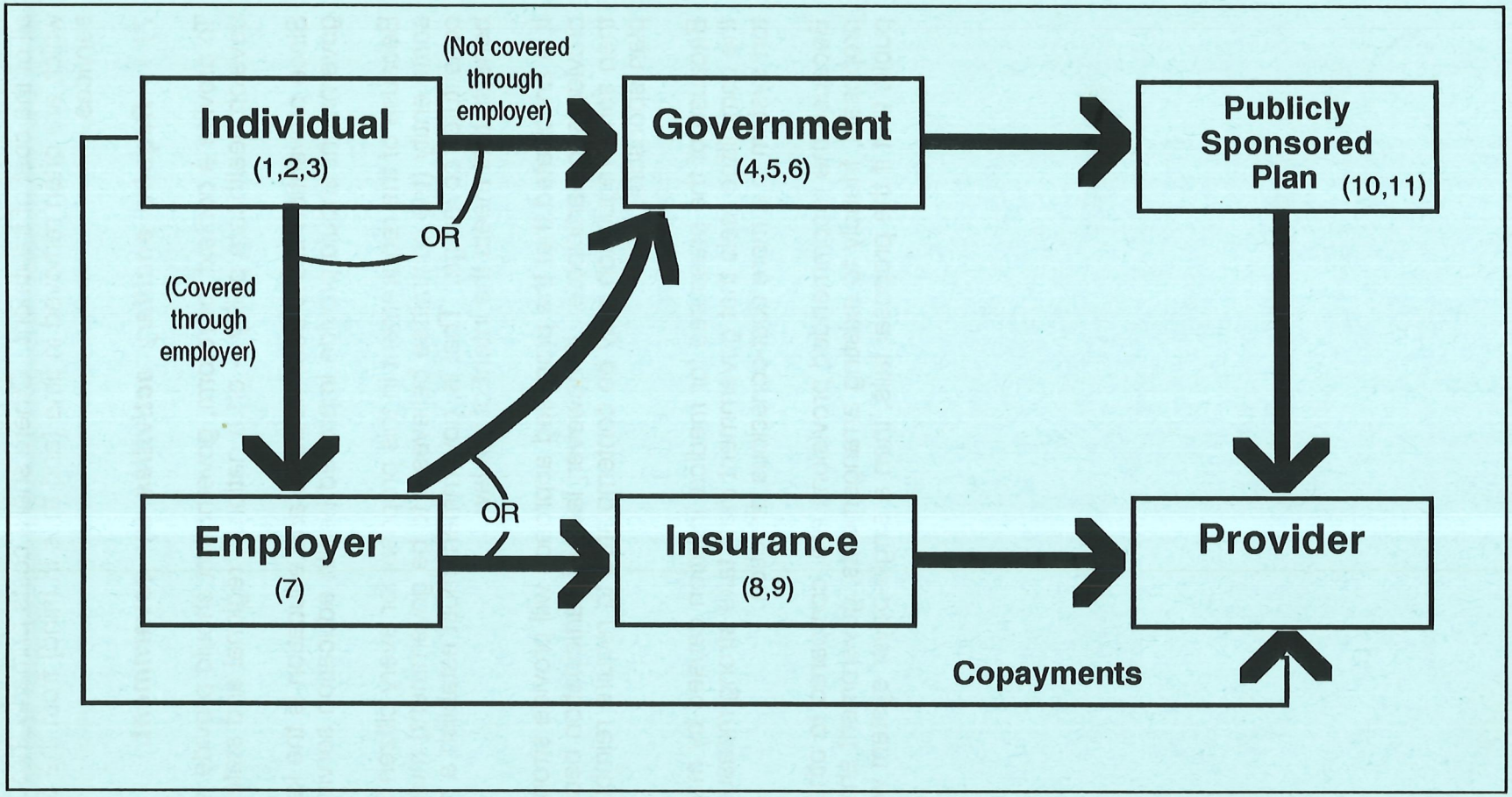
Because of the requirement in this proposal for every citizen to carry coverage, some entity (the committee believes it to be government) must establish what constitutes coverage. That is, government must establish a minimum level of benefits that meets the intent of the law.

It is anticipated that the proposed approach will provide strong incentives for providers to participate. If, however, lack of participation becomes a problem then some regulation may be contemplated to require reimbursement through plan sponsors.

Because of the pressures for medical inflation caused by malpractice litigation, the committee feels that government must take strong measures to reform the tort system in a more cost-conscious direction.

Because the recommended provisions are, compared to other reform proposals, friendly to existing arrangements, government should inform the public that if the proposal fails, then a single-payer system will be implemented.

Simplified Overview of the Flow of Funds



1) Mandatory coverage through either an employer-sponsored plan or a publicly sponsored plan.
2) Out-of-pocket payment for each episode of care, according to ability to pay.
3) Payment of some portion of premium for employer's plan — or payment of tax toward publicly sponsored plan.
4) Regulation of maximum allowable premium increases.
5) Quality monitoring and support for protocol research.
6) Reform of tort system.
7) Option to provide coverage or pay tax toward publicly sponsored plan.
8) Required "community rating."
9) Required acceptance of any applying employer group.
10) Because of sliding scale and worse risk for this group, subsidy will be required through tax or else surcharge on other insurance.
11) Operation could be be any of several means, e.g. contracted administration, contracted inclusion in carriers' lines, or direct government operation.

PYRAMID LIFE SINCE 1913
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February 12, 1990

Testimony of Walter Whalen Before The House Committee
On Mandated Benefits, February 12, 1990

Mr. Chairman, Members of the Committee,

I am Walter Whalen speaking today on behalf of Pyramid Life Insurance Company of Mission, Kansas. With the exception of Blue Cross and Blue Shield, Pyramid Life is the only life insurance company chartered and domiciled in the state of Kansas with health insurance as its primary line of business.

In my discussion with the Committee Thursday afternoon on health insurance rates and rating procedures, I attempted to explain the various factors that contribute to the cost of health insurance. My comments today should be considered an extension or continuation of these earlier comments, since mandated benefits have a tremendous effect upon the cost of health insurance.

Referring to my previous comments, I compared a health insurance company to a transfer agent pointing out that basically we collect money from one group to pay to another. Obviously therefore, the more types of coverage the company has to pay for, or the types of practitioners the company must pay, the more we must charge our policyholders. This seems so obvious, that it hardly seems worth mentioning. However, over the years, the state of Kansas has mandated minimum standards and mandated benefits for more than eight conditions. These eight conditions have noticeably increased premium costs.

Perhaps the practice of mandating benefits or more properly extending benefits seems such an attractive move is that there is a certain amount of deception involved. For example, in just about every bill referring to mandated benefits, the proposed bill states that the insurance company "must provide" certain benefits. This sounds rather reasonable. However, what the bill actually means is that the consumer, the person wanting insurance must buy and pay for this extension of coverage whether he wants this particular coverage or not. The insurance company is not providing; the consumer is paying.

Just what are these mandated benefits? In alphabetical order they are Alcoholism, Allied Practitioners, Discrimination against the handicapped, Drug Addiction, Maternity and Complications of Pregnancy, Mental Illness, Newborn Child Provision, and Mammography. Now it seems advisable that everyone should have these coverages. However, there are many who do

Attachment 5

not want all this coverage. Let us consider the complications of pregnancy mandate. Obviously, in the state of Kansas there is a large number of women who either by choice or because of a physical condition will not bear children. Nevertheless, if they want health insurance in the state of Kansas, they must buy and pay for coverage for complications of pregnancy even though they will never be able to use this benefit. The same can be said of drug addiction and even alcoholism. Many people in Kansas, because of religious or moral principle, will never be involved in drug addiction. Many more, will never be victims of alcoholism. Yet, despite their religious or moral convictions, if they wish to have health insurance in the state of Kansas, they must buy and pay for this coverage.

In other words, by mandating benefits or coverage as a prerequisite for obtaining health insurance coverage in the state of Kansas, the state has limited the freedom of choice of the consumer. It has effectively stated that you must buy and pay for coverage that you may not want and that you may never need.

Just what is the cost of mandated benefits. After all, the theory seems to be that by spreading the cost over a number of people, the cost itself is rather minimal. This is not necessarily true. Mandating coverage in the state of Kansas for alcoholism and drug addiction increases the annual rate for a nonsmoking male aged 40 by 13.2%. Now this might not seem too large an amount if you are thinking only of the Johnson County yuppie zooming from singles bar to singles bar in his BMW, however, when you realize that it also applies to the farming couple in western Kansas who are fighting nature daily in an attempt to keep their heads above water, or that it also applies to the single mother in Wichita or Wyandotte County who is breaking her back every day at McDonald's trying to buy food and clothing for herself and her children, this amount is far from minimal.

I did not run cost studies on all eight of the mandated benefits. Obviously, some will be less and others will be more, but if each of these mandated benefits increases the premium only 5% each, mandated benefits have effectively increased the cost of coverage 40%.

What then has been the result of mandating coverage in the state of Kansas. We have already seen that one result is unnecessarily high health inusurance premiums for a great number of people. Another result is that it is now impossible in the state of Kansas for the consumer to purchase a bare bones policy. While it is very nice to think that everyone should have complete coverage, many people cannot afford it. They are willing to buy and pay for coverage for the usual or average conditions we encounter daily, but they are unable to pay for all of the conditions mandated. The result is that many people are effectively barred from purchasing insurance. Others have been forced to drop the insurance they have carried for years when new mandated benefits increase their premium to the point where it cannot be afforded.

We also find that many owners of small businesses have been forced to curtail or eliminate the health insurance they provided for their employees since they can no longer afford this employee benefit. Now we heard from a witness Thursday representing LaHood & Associates, a third party administrator for group benefits, that he was unaware of any small business dropping employee benefits or going self-insured in an effort to avoid mandated benefits. This frankly amazed me since a representative of the Kansas Small Business Association had testified before this Committee time after time that small businesses had to restrict employee benefits because they could not afford them. Reviewing the LaHood & Associates testimony gives a clue as to why there is this contradiction. The representative of LaHood & Associates stated that their average sized group was 400 employees and that they would not consider administering a plan for a group of less than 100 employees. Frankly, after 35 years in Kansas, I do not feel that 400 employees or even 100 employees is what the average Kansan would consider a small business.

Thank you very much for the opportunity of continuing or supplementing the testimony I gave Wednesday. I realize that the theory of mandated benefits is a very attractive one. I hope that my comments this morning have pointed out that this is most frequently a self defeating attraction.

If you have any questions, I will try to answer them.

K·A·N·S·A·S HMO ASSOCIATION

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12 February 1990

TESTIMONY BEFORE HOUSE INSURANCE COMMITTEE

PERTAINING TO HEALTH CARE MANDATES

I am Meyer L. Goldman of Kansas City, president of the Kansas HMO Association. The members of our association provide comprehensive health care to more than 250,000 Kansas residents on a pre-paid basis. Our subscribers are for the most part employees of participating business firms. The subscribers (or "members") voluntarily choose to participate in the health maintenance organization in preference to other health care payment programs offered by the employer.

In return for choosing to be cared for by our employed or participating physicians, our members receive broader benefits (particularly in the area of preventive and routine care), have few or no copayments, and pay no bills other than the monthly prepayment.

The establishment of mandates by state law hampers our operation and contributes substantially to the escalating cost of health care delivery. We believe that each added mandate works against improvement in benefits available to consumers. It raises the cost beyond the ability to pay. It encourages employers to switch to less desirable health care delivery systems that avoid the mandates.

State mandates usually come in four forms: mandates that require **participation of particular providers** (podiatrists, psychologists, etc.; **mandates for specific benefits** (drug and alcohol abuse treatment, breast reconstruction, etc.); **services for particular population groups** (newborn, etc.) and **services for specific diseases** (diabetes, Altzheimer's, etc.) Inclosure #1 is a well-documented issue statement produced in 1988 by Group Health Association of America, the major trade organization of the HMO industry.

As an example of the effect of mandates on cost, the HMO with which I am associated, Prime Health in Kansas City, analyzed its experience in in-patient drug, alcohol and mental health care costs for its first 12 years of existence. The results are contained in Inclosure #2.

For our first five years there were no such mandates in either Missouri or Kansas. In 1980 Missouri adopted a law requiring optional inpatient benefits at the same level as medical benefits (100%) In 1981 a Missouri law made such benefits mandatory. In the next five years inpatient discharges for drug, alcohol and mental health were 218 per cent of the previous rate, although total discharges rose only three per cent.

In the two years following adoption of the Kansas mandate in 1986, D&A and mental health discharges were 181 per cent of the 1981-86 rate. This is only one of the mandates under which we operate.

As another example, Missouri is now considering a bill that would require coverage of annual mammography for women over 35. Kansas already has a mammography mandate. A fiscal note attached to the Missouri proposal estimated that the cost would be almost $1 million to the state for a plan covering highway and some other workers. The note did not include the cost for benefits paid by subordinate government entities or separately funded programs.

These costs must be reflected in our charges. Even if the costs of all health plans were equally affected, the result would be harmful to good health care delivery, because the costs would be rejected by increasing numbers of employees who must share some or all of the cost of personal or dependent protection. These people will join the growing number of ininsured workers or dependents whose care is paid by the state, or by cost-transfer to covered workers.

However, mandates greatly affect the "level playing field" under which health plans operate because rapidly growing numbers of employers are offering programs which are completely exempt from state mandates. The federal Employees Retirement Income Security Act (ERISA) preempts state regulation and prohibits state control. Inclosure #3 is a presentation delivered in December 1987 at a conference of the International Foundation of Employee Benefit Plans. This organization includes several thousand major industrial and commercial firms, and thousands of multi-employer, jointly-operated labor-management trust funds authorized by the Taft--Hartley Act.

The International Foundation presentation gives detailed information on the ERISA exemptions, cites examples of the overturning of state laws intended to avoid the exemptions and provides instruction on how to set up an effective ERISA program.

More than half the protected workers in Kansas now are covered by ERISA plans. Therefore already less than half can be affected by a Kansas state mandate.

As long as state mandates exist, managed care systems that typically offer broader, less expensive protection than competing plans are at a great disadvantage and the health care of the people is reduced. Let me point out that health maintenance organizations are not opposed to providing services that are typically mandates: most of

them do offer such services as needed. Federally-qualified health maintenance organizations are required by their qualification to include certain services. HMOs believe that it is cost-effective to prevent diseases rather than treat them once they are incurred. Our objective is to provide the best, broadest, most efficient health care service possible.

We cannot do this if we are forced out of the market by an unlevel playing field. Each mandate makes the ground rougher. And it is our belief that groups differ widely in their interest in mandated benefits. Please remember that each of our members has voluntarily chosen the HMO as his or her health care deliverer. And each has the option of changing to another form of protection at least once a year, if he or she is dissatisfied.

The tremendous growth of health maintenance organization enrollment in the past 14 years is evidence that our product is desired by consumers, and can compete in a fair and equally structured market. We suggest that the degree of protection for Kansas citizens can be increased and the cost of the protection can be controlled better without the mandates.

Thank you very much.

THE IMPACT OF MANDATED BENEFITS ON HMOs

ISSUE:

This issue paper examines the appropriateness of state laws requiring health maintenance organizations (HMOs) to provide specific mandated benefits or services in addition to basic benefits. These mandated benefits bills grant HMO enrollees access to frequently costly and often unwanted services while decreasing the availability of benefits in demand.

HMOs are currently required by Federal and most state laws to provide a comprehensive set of benefits, without limitation as to time and cost, including:

- physician services, including consultant and specialist referrals;
- unlimited outpatient services;
- 365 days of inpatient services;
- medically necessary emergency services;
- 20 outpatient visits per year for short-term evaluative or crisis intervention mental health services;
- diagnosis and medical treatment and referral services for alcohol and drug abuse, including detoxification;
- diagnostic lab and diagnostic and therapeutic radiologic services;
- home health services; and
- preventive health services, including immunizations, well-baby care from birth, periodic health evaluations, family planning services, infertility services, eye and ear examinations for children through the age of 17.

Legislative proposals to increase benefits are pursued primarily by provider groups for economic reasons. Ultimately, these bills will raise HMO costs and subsequently employer or other purchaser costs.

BACKGROUND:

Although states began to pass them as early as 1956, the number of mandates enacted accelerated rapidly during the 1970's. The growth of mandates is partially attributable to consumers demanding more comprehensive insurance coverage, both to decrease financial exposure and to achieve an expanded state of well-being or health.[1] Between 1972 and 1979, the average number of mandates enacted was 40 per year, with a peak of 75 in 1975.[2] These mandates can be divided into four basic categories:

- <u>specific services</u> (drug and alcohol abuse treatment, breast reconstruction);
- <u>services for particular population groups</u> (newborns, adopted children);
- <u>services related to specialty groups</u> (podiatrists, psychologists); and

- services for specific diseases (diabetes, Alzheimer's).[3]

Between 1980 and 1986, the average number of enacted mandates was 39 per year with a peak of 53 in 1980. By the end of 1986, the total stood at 645. While the number of 1987 mandates decreased slightly, state legislators introduced approximately 150 mandated benefits proposals.[4]

RECENT DEVELOPMENTS:

In 1987, state legislatures enacted numerous mandates pertaining to HMOs, including the following: coverage of adopted children from time the adoption process begins and child is placed in the home, alcoholism and drug abuse treatment, cardiac rehabilitation expenses, chiropractic services, services for cleft lips and/or palates in children, diabetes self-management programs, hair prostheses for alopecia areata, in vitro fertilization, maternity benefits, mental health, newborns, sickle cell anemia tests, and treatment for temporal mandibular joint (TMJ) disorder.

DISCUSSION:

Sponsors of mandated benefits are generally either providers that will gain professionally from passage or, in a very few instances, consumer interest groups. These proponents argue that: 1) there is an unmet need among the public and that a mandate would increase access to the service; 2) mandates reduce costs; and 3) mandates presently required of health insurers and proposed to be required of HMOs level the playing field between managed care and traditional carriers.

On the other hand, opponents (primarily coalitions of HMOs, other third-party payers, and employers), contend that mandates:

- force employers, employees and other purchasers to buy benefits, whether or not they want or can afford them;
- increase costs; and
- cannot level a playing field that's already lopsided.

Because of their primary concern about solvency, the National Association of Insurance Commissioners (NAIC) is also strongly opposed to mandated benefit statutes.

Employers and Employees Should Have the Right of Refusal

For both economic and freedom of choice reasons, decisions about benefits in addition to basic benefits should be left to the marketplace. Only in this way will employers have the flexibility to meet their employees's needs by offering an

affordable mix of desirable benefits. Employers and employees should not be required to pay for a benefit they do not want.

They should have, for example, the option of offering either mental health or dental services, or both, rather than being required to offer one or the other. If a costly benefit is dictated, options may be limited to extending this benefit exclusively.

Benefit plans that are required to include additional specific services may attract individuals who will tend to utilize such benefits and discourage low utilizers from purchasing comprehensive packages because of the premium's prohibitively high cost. Low utilizers of a mandate will tend to reduce the amount of their insurance premium by opting for a less comprehensive set of benefits. The result is a decrease in coverage, rather than more insurance as the mandate intends.

The Increasing Cost of Health Care

At a time of high medical inflation, the general thrust of many federal and state health care reform proposals is cost containment. HMOs are a strong and distinctive feature of these initiatives, evidenced by contracts with the federal and state governments to enroll Medicare beneficiaries and medical assistance recipients.

Generally, the costs of mandated benefits are passed through to employers, employees, state employees, or individual subscribers in the form of increased premiums. While the intent may be to increase the scope of insurance coverage, mandating additional benefits can have an adverse effect on the ability of persons to obtain health benefit coverage.

The high cost of these additional benefits forces many small businesses to purchase less comprehensive insurance packages or to pay for benefits which they and their employees do not want. Ultimately, the increase in mandated benefits causes some employers and/or employees to forsake health insurance entirely, adding to the number of the underinsured or uninsured.

Because state legislators are reluctant to increase taxes to fund social service programs, mandated benefits act as a "hidden tax" on state residents and employers who must pay for another's right to benefit from required coverage.[5] In Maryland, for example, in 1985 the average estimated cost per employee due to 29 mandates was $533 for typical family indemnity coverage, or 17 percent of the total premium cost. In the same year in Kansas, 13 mandates amounted to $237.12 of the annual employee indemnity premium. In 1984, a New York outpatient mental health mandate contributed $118.50 to individual and family indemnity premiums (on the average).[6]

The Playing Field: Level or Lopsided?

It is no accident that enactment of the HMO Act of 1973 coincided with the growth of state mandates. The same changes in societal values responsible for increasing the demand for more complete health insurance coverage provoked Congress to include comprehensive benefits in the federal HMO statute. Serving in part as a substitute for national health insurance, this enhanced set of benefits increased access to health care for millions of Americans.

Some health insurers contend that expanding current mandates to include HMOs levels the playing field. This notion might have more credence if the existing playing field were level, but it is not. As noted below, self-insured plans are not subject to mandates. If mandate requirements apply to HMOs, the effect is a greater burden and therefore not a level playing field.

Unlike indemnity carriers, HMOs provide a wide range of benefits with no deductibles and nominal copayments. Other requirements, such as prohibitions against waiting periods and pre-existing conditions would lead to adverse selection and distinguish HMOs from indemnity insurers, causing mandates to be more burdensome to the HMO industry.

The ERISA Pre-emption Creates Inequities

Increased mandated benefits may also contribute to the trend of large businesses to self-insure. The ability of employers to escape the economic hardship of mandated benefits (as well as premium taxes and solvency requirements) by converting to self-insured contracts, excluding them from state regulation under the provisions of ERISA, creates an unlevel playing field and grants self-insured groups an unfair competitive advantage.

Approximately 8 percent of all employment-related health plans were self-insured in 1984, but more than 50 percent of all employees with health insurance participate in self-insured plans.[7] Ultimately, saddled with numerous mandates and high administrative costs because they don't self-insure, small businesses are the losers in this game. The smaller employers are the ones that will either purchase less comprehensive packages or drop health coverage entirely, again contributing to the number of the uninsured.

The state of Nebraska has approached this problem by passing a bill prohibiting enactment of mandated benefit laws until the ERISA problem is resolved. A similar measure is expected to be introduced in Wisconsin.

Another Approach: Cost/Benefit Analysis

The increased awareness of state legislators of the costs involved in mandating specific services has led nine states to require environmental impact analyses of mandates before they can be enacted by the legislature.

Five of these laws were enacted in 1987 (Hawaii, Florida, Maryland, Louisiana, and Montana) and the four preceding bills were passed between 1984 and 1986 (Washington, Oregon, Arizona, and Pennsylvania).[8] In 1988, Wisconsin has been holding hearings on a similar bill and Minnesota is expected to introduce this type of legislation.

Generally, these cost/benefit analyses take into account:

- the extent to which the treatment or service is needed and available;
- the extent of financial hardship resulting from lack of coverage;
- the level of public demand and interest of collective bargaining agents in negotiating for a particular coverage;
- the impact of similar mandates in other states;
- the impact on an insurer's administrative expenses; and
- the extent to which coverage would increase total health care costs and utilization or would serve as an alternative for a more expensive service or treatment.[9,10]

In addition to the HMO and insurance industries, this approach is supported by employers and the National Association of Insurance Commissioners.[11]

The HMO Alternative

Recent statistics show that indemnity premiums are now on the rise while HMO premiums are remaining fairly stable. In the final analysis, legislative initiatives that mandate costly benefits will have a harmful impact not only on HMOs but on consumers, businesses and state employees. The HMO industry is not opposed to specific benefits or services but to mandated coverage of such benefits.

Mandated coverage meeting one interest group's needs will lead to higher health care costs for the majority. The decision of what benefits are provided to whom should be left to the bargaining table and the negotiations that occur between HMOs and health care purchasers. Leaving this process alone will ensure that employee groups are satisfied with their health benefits package instead of paying for unwanted coverage.

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EFFECT OF MANDATED DRUG, ALCOHOL AND MENTAL HEALTH BENEFIT MANDATES

Prime Health has analyzed its experience in inpatient drug, alcohol and mental health care costs for the 12 years of its existence.

During the first five years of operation, these benefits were not required by either Missouri or Kansas. In August 1980 a Missouri law mandating optional inpatient mental health benefits became effective. In January 1981 the Missouri law required the benefits. The Kansas law mandating the benefits became effective July 1, 1986. All required benefits the same as medical (100%).

For the first five years before the Missouri mandate the mean number of discharges per 1,000 subscribers for D&A and psychiatric cases was 1.95 out of total discharges of 74.6 percent of all discharges.

In the five years of Missouri mandating the mean number of discharges for D&A and psychiatric cases was 4.26 out of total discharges of 76.9, an increase of 218 percent in number of D&A and psychiatric cases. This represented 5.5 percent of total discharges.

In the first two years of Kansas mandate, the number of discharges for D&A and psychiatric cases was 7.69 out of total discharges of 76.3, an increase of an additional 181 percent, even though total discharges were reduced slightly. D&A and psychiatric cases have reached 10.1 percent of total discharges.

In arriving at the figures our financial analysts converted raw data logarithmically for comparison, and a "deflator" was computed to apply to increased rates for D&A and psychiatry to allow for changes in overall plan utilization (such as aging of the population.) The weighted average cost for the services was $4,056 for hospitalization only.

The estimated total cost of this one mandate alone is an additional $1,500,000. This adds an average of at least $52 to the cost of each covered contract.

DISCHARGES PER 1,000 PER YEAR

TIME FRAME	COMBINED D&A & PSYCHIATRIC	ALL ACUTE HOSPITALIZATIONS
Nov'76-June'77	3.1	81.3
July'77-June'78	1.6	74.0
July'78-June'79	1.5	74.0
July,79-June'80	3.0	75.2
July'80-June'81	2.0	75.1
July'81-June'82	3.1 (1) (2)	80.0
July'82-June'83	3.7	79.1
July'83-June'84	4.2	75.7
July'84-June'85	4.7	76.9
July'85-June'86	6.2	73.1
July'86-June'87	7.3 (3)	74.8
July'87-Dec'87	8.1	77.9

(1) Missouri law requiring optional inpatient mental health same as medical (100%) effective Aug. 13, 1980.

(2) Missouri law mandating inpatient D&A same as medical (100%) effective Jan. 1, 1981.

(3) Kansas law mandating inpatient mental health same as medical (100%) effective July 1, 1986.

SUMMARY

	Geometric mean of discharges/1000 D&A & psychiatric	Geometric mean of discharges/1000 plan overall
Prior to Mo. mandated benefits:	1.95	74.6
1st 5 years after Mo. law:	4.26	76.9
difference	**+218%**	**+3%**
1st 2 years after Kan. law:	7.69	76.3
difference +	**+181%**	**-0%**

Weighted average, cost per discharge, D&A and psychiatric (hospital costs only): $4,056.

I RNATIONAL OUNDATION OF EMF OYEE BENEFIT P IS'
33rd ANNUAL EMPLOYEE BENEFITS CONFERENCE
December 4-9, 1987 San Francisco, California

INCLOSURE # 3

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Federal and State-Mandated Benefits

Monday, 1:30-2:45 p.m.
Tuesday, 9:45-11:00 a.m.

Gateway To
PROFESSIONAL EXCELLENCE

Federal and State-Mandated Benefits

Timothy J. Parsons

I. Introduction

NOTES

A. General categories of mandated benefits

1. *Mandated coverage* for certain groups uninsurable, underinsured and unemployed

2. *Mandated types* of benefits—alcohol and substance abuse and rehabilitation, psychiatric care, etc.

3. *Mandated provider* coverage—chiropractors, podiatrists, social workers, home health care agencies, etc.

B. Statutory framework

1. ERISA definition of an *employee welfare benefit plan* (ERISA Section 3(1), 29 U.S.C. §1002(1)):

> The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in Section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

2. ERISA establishes a uniform body of federal law to govern the establishment and operation of all types of employee benefit plans. To implement this purpose, Section 514 of ERISA, 29 U.S.C. §1144, provides for preemption of all state laws which "relate to" employee benefit plans.

NOTES

a. But ERISA does not preempt other federal laws (ERISA Section 514(d), 29 U.S.C. §1144(d)); see, e.g., *Rebaldo v. Cuomo,* 749 F.2d 133, 6 EBC 1001 (2d Cir. 1984), or certain specific categories of state laws—insurance, banking or securities.

3. Court decisions to date indicate that there are four primary categories of state laws which are preempted by ERISA.
   a. Laws which regulate the type of benefits or terms of ERISA plans
   b. Laws which create reporting, disclosure, funding or vesting requirements for ERISA plans
   c. Laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans
   d. Laws and common-law rules that provide remedies for misconduct growing out of the administration of an ERISA plan

   Martori Bros. Distributors v. James-Massengale, 781 F.2d 1349, 1356-58 (9th Cir.), *cert. denied,* 107 S.Ct. 435 (1986) (collecting cases in nn.15-19). Preemption of state laws depends "on the conduct to which law is applied, not on the form or label of the law." *Scott v. Gulf Oil Corp.,* 745 F.2d 1499, 1504 (9th Cir. 1984)

   The extremely broad scope of ERISA preemption was reemphasized in two recent decisions: *Pilot Life Insurance Co. v. Dedaux,* 481 U.S. _____, 8 EBC 1409 (April 6, 1987); and *Metropolitan Life Insurance Company v. Taylor,* 481 U.S. _____, 8 EBC 1417 (April 6, 1987).

4. While ERISA establishes regulation of employee welfare benefit plans as an area of exclusive federal concern, aside from its general reporting and disclosure requirements (ERISA Sections 101 to 110, 29 U.S.C. §§1021 to 1030) and provisions governing fiduciary responsibility (ERISA Sections 402 to 414, 29 U.S.C. §§1102 to 1114), ERISA does not have provisions which directly govern either the eligibility requirements or specific types of benefits that may or must be provided by employee welfare benefit plans or the means by which those benefits are to be provided. Section 3(1) of ERISA simply states that a welfare benefit plan *may* provide various types of benefits and that it may do so "through the purchase of insurance or otherwise. . . ."

   The following specific ERISA standards are not applicable to employee welfare benefit plans.

NOTES

a. Participation, vesting and benefit accrual (ERISA Section 201(1), 29 U.S.C. §1051(1))
b. Funding (ERISA Section 301(a)(1), 29 U.S.C. §1081(a)(1))

5. On the other hand, regulation of the "business insurance," including detailed supervision of the content and coverage of individual and group insurance policies, has traditionally been an area of exclusively *state* concern and extensive state regulation and supervision, as permitted by federal law (the McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.*).

6. Importance of state-mandated benefits to employee welfare benefit plans. Depending upon their applicability, such state laws can have major impact on
   a. Plan design and structure
   b. Cost and funding considerations

7. ERISA preemption provisions recognize this situation and thereby create the present areas of concern and uncertainty.

   The relevant portions of Section 514 of ERISA, 29 U.S.C. §1144, are:

   > (a) Except as provided in subsection (b) of this section the provisions of this subchapter . . . shall supersede any and all State laws insofar as they now or hereafter relate to any employee benefit plan. . . .
   >
   > * * *
   >
   > (c)(1) The term "state law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.
   > (2) The term "state" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans. . . .

8. The two subparts of the preemption provision which have caused the most confusion and litigation are the so-called "savings clause" and the "deemer clause."
   a. The savings clause is Section 514(b)(2)(A), which states that:
      Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt

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or relieve any person from any law of any State which regulates insurance, banking or securities.

b. The deemer clause is Section 514(b)(2)(B), which states that:

(B) Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts. . . .

II. Impact of State Legislative and Regulatory Developments on Trust Fund Structures and Operating Documents

A. Impact of mandated benefits upon plan design and structure

B. Impact of mandated benefits upon plan claims experience and cost factors. The "cost" of benefits provided through insurance policies inevitably includes elements of the carrier's risk, retention and profit, as well as state premium taxes.

C. Impact of mandated benefits upon the ability of trustees to respond to changes in conditions

D. State-mandated benefit laws are not consistent or uniform, which results in inconsistencies and increased administrative complexities for regional or national plans.

E. Mandated benefits significantly limit the discretion and flexibility of trustees and plan sponsors or collective bargaining parties.

1. This potential intrusion by state regulation is contrary to the emerging view of federal courts, when reviewing legal challenges to decisions made concerning matters of basic plan structure—whether made by joint boards of trustees, collective bargaining parties or plan sponsors, to defer to such decisions and not subject them to review under a standard of "reasonableness." This is a significant departure from the reasoning of prior decisions under Section 302(c)(5) of the Labor-Management Relations Act.

The recent decisions follow the reasoning of the Supreme Court's decision in *UMWA Health & Retirement Funds v. Robinson,* 455 U.S. 562 (1982), which held that federal

courts do not have authority to review collectively bargained eligibility requirements for reasonableness and specifically rejected the reasoning of earlier appellate court decisions.

Thus, in *Short v. UMW 1950 Pension Trust*, 728 F.2d 528 (D.C.Cir. 1984), the court held that, absent a conflict with a specific provision of ERISA or some other federal law or policy, trustees do not breach their fiduciary duties in administering a pension plan (see ERISA Section 404(a)(1)(D)) by acting in accordance with eligibility requirements that have been established by the employers and union in a collective bargaining agreement. See also *UMW, District 2 v. Helen Mining Co.*, 762 F.2d 1155, 6 EBC 1859 (3d Cir. 1985), where the court sustained the trustees' consistent interpretation of benefit eligibility requirement and ruled that collectively bargained requirement of prior administrative approval of certain surgery could not be reviewed for reasonableness.

See also *Saunders v. Teamsters Local 639 Pension Trust*, 2 EBC 1961 (D.C.Cir. 1981) (LMRA Section 302 allows trustees broad discretion to choose among rational alternatives in setting eligibility standards); *Central Tool Co. v. IAM National Pension Fund*, 811 F.2d 657, 8 EBC 1268 (D.C.Cir. 1987) (discussing possible differing standard of review for eligibility rules adopted through collective bargaining as opposed to adoption as result of trustees' exercise of discretion); *Bruch v. Firestone Tire and Rubber Company*, _____ F.2d _____, 8 EBC _____ (3d Cir. 1987) (decisions to deny benefit claims made by joint boards of trustees are entitled to "deference," but decisions made by plan administrators who are employees of the sponsoring employer, and thus potentially subject to bias and conflict of interest, should be subject to *de novo* review by court).

Although the *Robinson* decision dealt specifically with eligibility requirements established in a collective bargaining agreement, in *Moore v. Reynolds Metals Co. Retirement Programs*, 740 F.2d 454 (6th Cir. 1984), the court applied the same reasoning in its review of a challenge to a disability benefit plan that had been established unilaterally by a single employer. In *Moore*, the court held that an employer is free to choose what benefits and eligibility requirements are to be included in a plan so long as any specific requirements of ERISA are satisfied. A court can review the trust-

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ees' administrative decisions with respect to the plan (under the arbitrary or capricious standard), but it cannot review the substantive provisions of the plan.

NOTES

III. Trend of State Insurance Departments to Mandate Certain Benefits

A. All states have some form of mandated benefits.

B. Most common types require that all group insurance policies issued in-state contain or provide for insurance coverages such as the following.

1. Treatment of mental and nervous disorders

2. Treatment of alcoholism and substance abuse

3. Coverage of infants from day of birth

4. Home health care

5. Coverage for handicapped children

6. Reimbursement for services provided by certain licensed specialty groups—osteopaths, chiropractors, podiatrists, etc.

7. Mandatory conversion rights upon termination

8. Election of continued coverage by laid-off or terminated employees, disabled employees, workers' compensation recipients, widows, etc. (This situation has been largely supplanted by COBRA, but how does a plan deal with a situation where there is a state insurance requirement which is inconsistent with COBRA?)

9. Mandated-provider laws, also known as "freedom-of-choice" or "antidiscrimination" laws, have been adopted in nearly every state. See "Note: ERISA Preemption of State Mandated-Provider Laws," 1985 *Duke Law Journal* 1194.

C. No disagreement that the mandated benefits are helpful to or needed by many persons, but at what cost? More importantly, *who* should be making the decisions as to what coverage should be provided—trustees? Or special interest lobbyists, state legislators and bureaucrats?

IV. Jurisdiction Over Self-Funded Health Care Plans

NOTES

A. In *Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts*, 471 U.S. 724, 6 EBC 1733 (1985), the Court clearly ruled that, due to ERISA preemption, the regulation of "self-insured" or "self-funded" health care plans, i.e., plans which provide benefits or pay claims directly from plan assets, is exclusively a federal concern and that any direct state regulation of such a plan is prohibited.

B. In *Metropolitan,* however, the Court also held that the insurance "savings clause" and the general law of insurance permit states to require that group insurance policies contain certain types of benefits or levels of coverage, e.g., minimum mental health care benefits, and that group insurance policies that are issued or sold to welfare benefit plans which choose to provide benefits through the purchase of insurance policies, i.e., "insured plans," must comply with all applicable state insurance laws. Thus, while direct regulation of a welfare benefit plan is prohibited, a degree of indirect regulation is permissible with regard to insured plans and to the extent that individual states have certain "mandated benefit" requirements.

   Under *Metropolitan Life,* the test whether a particular state law constitutes or qualifies as regulation of the "business of insurance" requires review of three criteria.

   1. The practice must have the effect of transferring or spreading a policyholder's risk.

   2. The practice must be an integral part of the policy relationship between the insurer and the insured.

   3. The practice must be limited to entities within the insurance industry.

C. Except for "mandated benefits," however, any degree of direct or indirect state regulation should still be prohibited in the following areas.

   1. Trustee appointment, removal, duties and responsibilities

   2. Reporting and disclosure

   3. Plan investments

   4. Plan funding or contribution requirements
      a. Limited exception for multiple employer welfare arrangements (MEWAs)

5. Plan eligibility requirements

NOTES

D. There is relatively little disagreement or confusion over plans which are at one end of the spectrum or the other, i.e., insured vs. self-funded/self-insured. Pure self-funding, however, may not be financially possible for a plan or prudent for its trustees.

The areas of ambiguity and litigation have arisen in the situations of plans which are self-funded with respect to payment of benefits, but which also have minimum premium, stop-loss or split-funded insurance coverage in order to protect the plan from excess or "catastrophic" claims. In these circumstances, where is the dividing line between insured and self-funded/self-insured status?

E. A welfare plan may contract with an insurance carrier to provide claims processing or handling services under an *administrative services only* (ASO) agreement *without* the plan being found to be an *insured plan* for purposes of compliance with state-mandated benefits requirements. See *Insurance Board Under the Social Insurance Plan of Bethlehem Steel Corp. v. Muir,* _____ F.2d _____, 8 EBC 1889 (3d Cir. 1987) (an insurance company which is providing only administrative services to an employee benefit plan is not engaged in "the business of insurance" and, therefore, is not subject to state regulation). See also *Howard v. Parisian, Inc.*, 807 F.2d 560, 8 EBC 1033 (11th Cir. 1987) (ERISA preempts state law claims of bad faith refusal to pay benefits and outrageous and intentional infliction of emotional distress asserted against insurance company which was the claims administrator of self-funded welfare benefit plan (nonfiduciary)); *Light v. Blue Cross and Blue Shield of Alabama, Inc.*, 790 F.2d 1247, 8 EBC 1191 (5th Cir. 1986) (ERISA preempts state law claims for bad faith refusal to pay claims, intentional infliction of severe emotional distress, breach of fiduciary duties and deceit, which were asserted against BCBS as claims administrator of self-insured plan); but see *Munoz v. Prudential Insurance Company of America*, 633 F. Supp. 564 (D.Colo. 1986) (ERISA does not preempt state law claims for breach of contract, negligence and strict liability against nonfiduciary of a self-funded welfare plan. As a nonfiduciary, administrator was not subject to regulation under ERISA); *Simmons v. Prudential Insurance Co.*, 641 F. Supp. 675 (D.Colo. 1986) (ERISA does not preempt state law claims asserted only against insurance carrier, which had issued stop-loss insurance policy and determined claims, although it was a fiduciary for ERISA purposes. Insurance carrier remained subject to regulation under state insurance laws, which included tort claims for breach of contractual and statutory duties of good faith and fair dealing, etc.).

F. The status of plans which are primarily self-funded, but which also have stop-loss or excess-risk insurance coverage, is somewhat unclear. NOTES

1. *St. Paul Electrical Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D.Minn. 1980) (Minnesota statutes imposing reporting, conversion and minimum benefit requirements could not be enforced against a plan which contracted with an insurer for stop-loss coverage)

2. *General Split Corp. v. Mitchell*, 523 F. Supp. 427, 2 EBC 1945 (E.D.Wisc. 1981) (plans were fully self-insured as to payment of benefits, but had contracts with stop-loss insurance carriers; ERISA preempted Wisconsin statutes which mandated certain conversion benefits and established a health insurance risk sharing plan for residents who were unable to secure ordinary health insurance coverage)

3. But see *Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund v. Baerwaldt*, 767 F.2d 308, 6 EBC 2033 (6th Cir. 1985). In this case, welfare plans had purchased a group insurance contract under which plans would pay all health and welfare benefits provided under the group policies up to an agreed-upon amount (the "claims liability limit" or "CLL"). After the CLL was reached, the insurance carrier was liable for payment of additional benefits. Thus, the plans were self-insured up to the CLL and beyond that they were insured for excess or catastrophic loss. Note that, under this arrangement, once the CLL was reached, the carrier apparently would make direct payment of benefits in excess of the CLL under the group policies.

   In these circumstances, the court found that ERISA did not preempt a Michigan insurance statute which mandated that all health insurance policies issued in-state provide certain levels of substance abuse coverage.

4. Other recent decisions differ from the holding of *Baerwaldt*, with the key distinction appearing to be whether the stop-loss policy provides that the insurance carrier will make direct payment of benefits to plan participants or whether the stop-loss carrier merely reimburses the plan for paid benefit claims which exceed the stop-loss attachment points (individual or aggregate).
   a. *Bone v. Association Management Services, Inc.*, 632 F. Supp. 493, 7 EBC 1419 (S.D.Miss. 1986) (plan was self-insured, but had a Lloyd's stop-loss policy which

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would reimburse the plan to the extent that a claim exceeded $15,000; the insurance policy insured the plan itself as opposed to the individual participants. Therefore, the utilization of the stop-loss policy did not convert the plan into an "insured" plan.)

b. *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga,* 801 F.2d 1157, 7 EBC 2295 (9th Cir. 1986) (welfare plan which utilized stop-loss insurance policy was not subject to Arizona common law prohibiting assignment of third party claims. The stop-loss coverage would reimburse plan in the event that more than a specified aggregate amount of claims was paid in a year. The stop-loss insurance did not pay benefits directly to participants.)

Accord, Moore v. Provident Life and Accident Insurance Co., 786 F.2d 922 (9th Cir. 1986).

5. But minimum premium group health plans, and possibly plans covered by stop-loss insurance coverage, may be subject to a state's insurance premium tax on all benefit payments, not just actual premiums. *General Motors Corp. v. California State Board of Equalization,* 815 F.2d 1305, (9th Cir. 1987). Plans were self-funded by employer and had "excess-risk" insurance policies under which plans paid all claims up to a trigger point (annual aggregate level of claims) after which insurance carrier was responsible for paying all claims above trigger point. Two advantages for employer from prior fully insured contracts—plans could retain use of funds until claims were actually paid and there would be reduced premium tax liability for insurer (which plans were required to reimburse). State sought to impose gross premium tax on amount of premiums paid to insurance carriers *and* amounts of benefits paid by plans. The court found that there was no ERISA preemption because the tax was imposed only on the insurance carrier and was a state law regulating the business of insurance.

V. Status Conflicts Between ERISA and State Insurance Departments

A. Responding to inquiries from state insurance department personnel

VI. Pertinent Court Decisions

A. ERISA preemption of various types of state-mandated benefits

NOTES

1. State law which required employers to continue to make health and welfare contributions on behalf of employees on workers' compensation. *Stone & Webster Engineering Corp. v. Ilsley,* 690 F.2d 489, 3 EBC 2141 (2d Cir. 1982)

2. State law which regulated third party prescription drug programs. *Blue Cross v. Peacock's Apothecary, Inc.,* 567 F. Supp. 1258, 4 EBC 1833 (N.D.Ala. 1983)

3. Hawaii Prepaid Health Care Act which required employers to provide specific health benefit plans. *Standard Oil Co. v. Agsalud,* 633 F.2d 760, 2 EBC 1559 (9th Cir. 1980)

4. No presumption of Michigan mandated benefit law for substance abuse coverage. *Baerwaldt, supra*

5. Missouri common law of subrogation. *Davis v. Line Construction Benefit Fund,* 589 F. Supp. 146, 5 EBC 1913 (W.D.Mo. 1984)

6. New Hampshire statute concerning extension of benefits to persons who are ineligible to continue to participate. *Dawson v. Whaland,* 529 F. Supp. 626, 2 EBC 2433 (D.N.H. 1982)

7. Wisconsin statutes on mandatory conversion benefits and health insurance risk sharing. *General Split Corp., supra*

8. State insurance regulations and state remedies for violations; preemption should not vary with differing methods of plan funding. *Drummond v. McDonald's Corp.,* 3 EBC 2209 (Cal. Super. Ct. 1982)

9. Illinois statute on mandatory conversion rights. *Russo v. Boland,* 4 EBC 1861 (Ill. App. Ct. 1982)

10. Maryland statute requiring group health insurance policies to cover services performed by licensed social workers. *Insurance Commissioner v. Metropolitan Life Insur. Co.,* 296 Md. 334, 463 A.2d 793, 4 EBC 2087 (Md. Ct. App. 1983)

11. Minnesota common law of subrogation. *Hunt v. Sherman,* 5 EBC 1741 (Minn. S. Ct. 1984)

12. Texas Insurance Code and Deceptive Trade Practices Act. *Felts v. Graphic Arts Employee Benefit Trust,* 680 S.W.2d 891, 6 EBC 1409 (Texas Ct. App. 1984)

13. Pennsylvania no-fault motor vehicle insurance act as applied to COB rules of a self-funded plan. *Kilmer v. Central Counties Bank,* 623 F. Supp. 994, 6 EBC 2685 (W.D.Pa. 1985)

14. Louisiana mandated benefits for mental illness treatment as applied to a self-insured welfare benefit plan. *Children's Hospital v. Whitcomb,* 778 F.2d 239, 6 EBC 2609 (5th Cir. 1985)

15. Virginia statute barring subrogation clauses in health and medical insurance policies as applied to a self-insured welfare benefit plan. *Dillard v. Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund,* 6 EBC 2558 (W.D.Va. 1985)

16. Arizona common law prohibiting assignment/subrogation of third party claims to welfare plan. *Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga,* 801 F.2d 1157, 7 EBC 2295 (9th Cir. 1986)

17. Oregon statute which prohibits employer from discriminating in compensation based on physical/mental impairment or specific medical conditions in exclusion from insurance coverage. *Johnson v. Montgomery Wards, Inc.,* 7 EBC 1857 (D.Or. 1986)

18. California Workers' Compensation Appeals Board award of additional service credits to disability benefit recipient. *Pacific Bell v. Workers' Compensation Appeals Board,* 231 Cal. Rptr. 484, 7 EBC 2585 (Cal. Ct. App. 1986)

19. West Virginia statute barring employers that provide medical insurance from reducing or canceling such benefits while employee is on temporary total disability. *Fixx v. UMWA,* 645 F. Supp. 352, 8 EBC 1077 (S.D.W.Va. 1986)

20. New Hampshire statute which extended health insurance benefits for 39 weeks after they would ordinarily have been terminated. *Cuttle v. Federal Employers Metal Trades Council,* 623 F. Supp. 1154 (D.Me. 1985)

21. ERISA did not preempt Kansas mandated benefit and mandated provider statutes (optometrist, dentist, podiatrist,

psychologist) as applied to insured plans. *Blue Cross and Blue Shield of Kansas City v. Bell,* 798 F.2d 1331 (10th Cir. 1986)

22. New Jersey statute which prohibited a labor organization from administering an employee benefit fund unless the labor organization met certain state-enacted criteria. *Hotel and Restaurant Employees and Bartenders International Union Local 54 v. Danziger,* 709 F.2d 815, 4 EBC 1947 (3d Cir. 1983)

23. But, there is no ERISA preemption where there is not a plan which is covered by ERISA. *Matthew 25 Ministries, Inc. v. Corcoran,* 771 F.2d 21, 6 EBC 2070 (2d Cir. 1985)

24. Full protection of ERISA preemption may not be available to MEITs and MEWAs, e.g., *Hamberlin v. VIP Insurance Trust,* 434 F. Supp. 1196, 1 EBC 2054 (D.Ariz. 1977); *Insurance & Prepaid Benefits Trust v. Marshall,* 2 EBC 1629 (C.D.Cal. 1981), *aff'd,* 4 EBC 1653 (9th Cir. 1982); *National Employee Benefit Assoc. v. Anderson,* 451 F. Supp. 458, 1 EBC 1717 (S.D.Iowa 1977); *Bell v. Employee Security Benefit Assoc.,* 437 F. Supp. 458, 1 EBC 1703 (D.Kan. 1977).

B. ERISA preemption in litigation involving either insured or self-insured welfare plans

1. In litigation which arises from the administration of employee benefit plans or the denial of claims, courts have consistently ruled that causes of action, whether based upon state common law or implied from other state laws, such as laws regulating insurance contracts or relations between an insurance company and its policyholders, to the extent that they are invoked by participants or beneficiaries as the basis of a claim for relief for injuries arising out of the administration of employee benefit plans "relate to" such plans and, absent an applicable exemption, are preempted by ERISA.

   Thus, to the extent that ERISA provides a means for redress of the alleged mishandling of benefits claims or other maladministration of employee benefit plans, it *preempts analogous causes of action, whatever their form or label under state law. Powell v. Chesapeake and Potomac Telephone Co.,* 780 F.2d 419, 421 (4th Cir. 1985), *cert. denied,* 106 S.Ct. 2892 (1986) (ERISA preempts state law claims for intentional infliction of emotional distress, breach of contract and unfair trade practices in connection with employer's alleged mishandling of disability benefit claims)

For example, in *Lee v. Weaver Associates*, 6 EBC 2699 (D.D.C. 1985), the court held that common-law claims for benefits based on breach of contract, quasi-contract, negligence and interference with contract rights were preempted by ERISA and observed that "Congress could not have intended that plaintiffs could circumvent ERISA, and the broad preemption clause, simply by asserting common law tort and contract claims." 6 EBC at 1700

2. Upon consideration of complaints alleging causes of action based upon a wide variety of state law claims relating to alleged wrongful denial of benefit claims, state and federal courts having consistently ruled that ERISA preempts all state and/or common-law causes of action against employee benefit plans. See, e.g., *Authier v. Ginsberg*, 757 F.2d 796 (6th Cir.), *cert. denied*, 106 S.CT. 208 (1985) (state common-law cause of action for discharge in violation of public policy is preempted by ERISA): *Miner v. International Typographical Union Negotiated Pension Plan*, 601 F. Supp. 1390, 1394 (D.Colo. 1985) (state law claims for wrongful and retaliatory discharge, humiliation and mental suffering and distress are preempted by ERISA); *Folz v. Marriott Corp.*, 594 F. Supp. 1007, 1020-21 (W.D.Mo. 1984) (ERISA preempts state law claims for intentional and negligent infliction of emotional distress, unjust enrichment, fraud, conversion, common-law contract actions and claims of wrongful discharge to prevent receipt of employee benefits); *Shaw v. International Association of Machinists and Aerospace Workers Pension Plan*, 563 F. Supp. 653, 658-59 (C.D.Cal. 1983), *aff'd*, 750 F.2d 1458 (9th Cir.), *cert. denied*, 105 S.Ct. 2678 (1985) (common-law cause of action for breach of contract preempted by ERISA); *Lucash v. Strick Corp.*, 602 F. Supp. 430, 436 (E.D.Pa. 1984), *aff'd without op.*, 760 F.2d 259 (3d Cir. 1985) (state law claims of knowing, intentional and/or reckless breach of duty of care, fiduciary duty and/or contractual obligation preempted by ERISA); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356-57 (9th Cir. 1984), *cert. denied*, 106 S.Ct. 183 (1985) (ERISA preempted common-law claims for breach of contract, promissory estoppel, estoppel by conduct, fraud and deceit, and breach of contract); *Provience v. Valley Clerks Trust Fund*, 209 Cal. Rptr. 276, 6 EBC 1153 (Cal. Ct. Appl. 1984) (tort claims for fraud, bad faith denial of benefits and intentional infliction of emotional distress are preempted by ERISA); *Hepler v. CBS*, 696 P.2d 596 (Wash. Ct. App.), *review denied*, 103 Wash. 2d 1041, *cert. denied*, 106 S.Ct. 343 (1985) (causes of action for violations of state insurance code and consumer protection act are preempted by ERISA).

NOTES

3. Common-law causes of action for breach of an implied covenant of good faith and fair dealing, a cause of action that generally has been derived from state insurance laws, are also preempted by ERISA. *Powell, supra,* 780 F.2d at 422-23. In its recent decision in *Pilot Life Insurance Company v. Dedaux,* the Supreme Court held that ERISA preempted state common-law tort and contract actions, asserted under theories of "bad faith" and "tortious breach of contract," asserting improper processing of a claim for benefits under an *insured* employee benefit plan. The Court determined that the Mississippi common law of "bad faith" was not a state law which "regulates insurance."

   Therefore, the fact that a welfare plan purchases group insurance policies to provide certain types of benefits which may be subject to certain mandated benefit requirements, e.g., life, accidental death and dismemberment, loss-of-sight benefits, or has stop-loss insurance coverage, is immaterial with respect to the applicability of ERISA's preemption provisions to claims asserted against plan fiduciaries or administrators in litigation arising out of plan administration or denial of claims. Section 3(1) of ERISA, 29 U.S.C. §1002(1), expressly provides that an employee welfare benefit plan may provide benefits "through the purchase of insurance or otherwise . . ." (see *Simmons v. Prudential Insurance Co.,* 641 F. Supp. 675 (D.Colo. 1986); *Bone v. Association Management Services, Inc.,* 632 F. Supp. 493 (S.D.Miss. 1986)), and the "deemer clause" provides that an employee benefit plan shall not be deemed to be an insurance company or to be engaged in the business of insurance.

   Thus, in *Kanne v. Connecticut General Life Insurance Co.,* 819 F.2d 204 (9th Cir. 1987), the court held that common-law claims against the insurance carrier of a welfare benefit plan for breach of contract and breach of duty of good faith and fair dealing and a statutory claim under the California Insurance Code for failure to pay claims reasonably promptly were preempted by ERISA. The court also held that the California common law of contract interpretation was not a law which regulated insurance.

4. Similarly, with respect to litigation against employee benefit plans based upon allegedly improper processing or denial of claims, the civil enforcement provisions of Section 502 of ERISA, 29 U.S.C. §1132, are exclusive. *Pilot Life Insurance Company, supra.*

NOTES

Lawsuits filed in state courts which allege maladministration of employee benefit plans or wrongful denial of benefit claims can be removed (transferred) to federal court even where the plaintiff has alleged only state causes of action. *Metropolitan Life Insurance Company v. Taylor,* 481 U.S. _____ , 8 EBC 1417 (1987).

VII. Conclusion

Catholic Health Association of Kansas

John H. Holmgren • Executive Director
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CATHOLIC HEALTH ASSOCIATION OF KANSAS

TESTIMONY

INSURANCE COMMITTEE
Dale Sprague, Chair
Barbara Allen, Vice Chair
Larry Turnquist, Ranking Minority Member

Monday, February 12, 1990

My name is John Holmgren, Executive Director of the Catholic Health Association of Kansas, which represents 28 Health Care Institutions (hospitals and nursing homes) in Kansas employing over 10,000 Kansans throughout our state and dedicated to the health and wellness of our citizens.

This committee is reviewing continuation of mandated health insurance benefits in the areas of Alcohol and Chemical Dependency, Nervous and Mental Disorders, Newborn Care and Mammography examinations. We, as major employers who pay health insurance costs, as institutions who provide care both to our employees and citizens of our state, are perhaps in a position to offer valid observations and recommendations as you review the status of mandated health insurance benefits.

The legislature in the past has found it in the interest of the citizens of the state to mandate coverage of these

benefits for the public health and welfare. We sincerely believe that they should be maintained not only because we have the opinion that they benefit people employed and covered by health insurance programs in our state, but also because they benefit employers, and ultimately the state and society as a whole.

While the cost of health insurance coverage has increased significantly - with medical coverage in 1988 costing an estimated $2,300.00 for each employee, up 19% from the previous year, - causing concern for all of us, elimination of mandated benefits may in fact result in a higher cost of benefits and in a higher cost to employers, the State of Kansas and society in general.

The current mandated coverages certainly are "minimal" in terms of coverage; with large co-payments for the patient for alcoholism and chemical dependency and nervous disorders (100% of first $100.00, 80% of next $100 and 50% to $2,640), and for newborn care (15th to 30th day of confinement in a hospital). Certainly, these benefits were mandated with consideration given to protecting our citizens from the catastrophic financial consequences in having a seriously ill newborn child or the serious affliction of alcohol/chemical addiction. It is a proper role for the state to "protect" it's citizens in an area as complex as health insurance benefits. Many of us even who are familiar with the health care field do not think

about or even understand our benefits until we are faced with an illness. Our citizens must be protected from unanticipated catastrophic financial loss from excluded coverage

Even a sophisticated citizen does not have the expertise to determine what coverage his or her health insurance plan has.

The lack of mandated coverage will also have negative financial consequences for our State. Persons not covered for alcoholism and chemical dependency and nervous and mental disorders are a population who untreated, are at risk of lacking gainful employment, and utilizing state health and welfare benefit programs. At a time when our state is facing a serious financial condition our legislature should not eliminate these mandates which will have the consequence of "shifting costs" to the State's health and welfare program.

Mammography must also be retained as a mandated benefit of Health Insurance programs in our state. The value of mammography in women 40 years and older has been widely and repeatedly documented in the medical literature. "Savings derived from a reduction in cost of treatment of earlier stages of breast cancer are greater than the cost of mammography, yielding a net monetary savings."1 It is now well accepted "that breast cancer screening in which mammography has a major role can result in substantial reductions in breast cancer mortality -- about 30%."2

Because of the benefit to the women of our state and a well documented positive cost-benefit, this mandated coverage should continue. The financial benefits of mammographic screening include a reduction in costs of health care and disability payments achieved through less radical treatment of earlier stage tumors and decreased costs related to hiring and training of new employees. Furthermore, society benefits from the continued productivity of women who are able to remain in the workforce.

While in these times of rapidly escalating costs of health insurance, it is certainly necessary to re-examine mandated benefits, we urge you to continue the benefits wisely mandated by the legislature in past sessions. Their continuation is necessary to protect our citizens from catastrophic financial consequences, to prevent additional utilization of our State's Health and Welfare Benefits system, and to continue the very positive cost/ benefit of mammography services to reduce the morbidity and mortality of breast cancer for women of our state.

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1 Eley, J. William, MD "Analyzing Costs and Benefits of Mammography Screening in the Workplace" AAOHN Journal,

May 1989, Vol. 37, No. 5, p. 171.

2 Shapiro, Sam, "General Motors Cancer Research Foundation, Chas. F. Kettering Prize: Determining the Efficacy of Breast Cancer Screening, Cancer, May 15, 1989.

Analyzing Costs and Benefits of Mammography Screening in the Workplace

by J. William Eley, MD

Decision analysis is a systematic evaluation of the underlying assumptions inherent in making choices. Clinicians and public health personnel spend much of their time evaluating situations that often require choosing between two or more alternatives—to operate or observe a client with abdominal pain; to spend money on education or treatment of the AIDS virus; to perform a myelogram or magnetic resonance imaging study on a cancer patient with back pain. Whether the choice is in the clinical or public health sector, the decision maker determines a course of action based on personal experience and knowledge gained from literature.

Decision analysis challenges one to clearly define goals, options, and underlying assumptions intrinsic to the decision making process to clarify the process and to reach more rational conclusions. Inability to obtain information critical to the analysis of a particular problem, or the revelation that one or more underlying assumptions are incorrect, may require additional information gathering and a subsequent change in the final decision.

Breast cancer is a cause of morbidity and mortality in women: mammography can reduce the mortality of breast cancer. A decision analysis approach to mammographic screening for breast cancer requires that the assumptions underlying the effectiveness of mammographic screening be analyzed, as well as the ultimate goals or outcomes associated with the institution of mammographic screening. The analysis of costs to an individual or group compared with the benefits expected to that individual or group is cost-benefit analysis. Frequently, cost-benefit analysis is performed on a decision analysis model.

DECISION ANALYSIS

Identification of the Problem

Although possibly self-evident, the statement of the problem is often not identical when viewed from different perspectives. For example, a public health official may think of a flu epidemic in terms of numbers of hospital beds required during the epidemic, the cost to society in days lost from work, or the institution of a vaccination program. A nurse practitioner would be interested in a vaccination program but may be more concerned with diagnostic criteria and treatment strategies for clients who present with a flu-like illness. Finally, an individual client may be concerned with days of work lost, cost and side effects of vaccination or treatment, and threat to individual health.

The relative importance of vaccination, lost work days, treatment, cost of treatment, and hospital bed utilization is subject to an observer's perspective. The decision analysis model requires identification of the perspective at the outset, thereby clarifying the decision maker's biases and priorities. Using breast cancer as an example, one observer could define the problem as a subset of problems secondary to a diet high in fat consumption, while another might determine the problem to be the pain and suffering of women in the terminal stages of disseminated disease. A concise definition of the problem must precede the search for the solution to the problem.

Specification of the Target Group

Once a problem is clearly defined a target group must be specified. Selection of the target group involves determination of individuals at risk for the particular problem. Other factors (ie, degree of risk, an ability to effect change within a group, and cost) may also influence the selection of a particular group.

Breast cancer is a cause of morbidity and mortality in women: mammography can reduce the mortality.

For example, a substance may cause cancer when inhaled and is known to be present in the air in one particular room of a plant. When planning to reduce exposure to this substance by instituting a ventilation mask requirement, the group required to wear the mask would have to be specified. Proximity to the source of the substance may influence the exposure of persons working in the room where the substance is present; however, persons in rooms

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TABLE 7
Savings from Reduction in Training of New Employees

5 years/20 years × $25,000 = $6,250 per life saved
Total savings = $6,250 × 1.9 lives saved = $11,875.

TABLE 8
Cost-Benefit of Mammography Screening Program

$734,565/1.9 lives saved = $386,613 per life saved
$734,565/(1.9 lives × 4.5 years) =
$85,914 per year of life saved < 65 years
$720,000/(1.9 lives × 19.5 years) =
$19,826 per year of life saved < 80 years

individual (see Table 6).

Savings derived from a reduction in training and hiring new employees can be estimated by multiplying the number of deaths prevented by the average cost of retraining a new employee, which will be estimated as being the cost of one year of average salary ($25,000). The full cost of hiring and retraining will not be saved since all employees retire eventually.

If the average worker is employed for 20 years, and preventing the death of an employee adds an average of five years to the employee's length of employment, then the cost of hiring and training a new employee can be avoided for an average of five years (see Table 7).

Total savings from labor saved, treatment costs, and hiring/retraining costs would therefore be $282,435.

The total costs of the mammography screening program can be computed by subtracting the savings from the cost of the program: $1,017,000 (total cost) − $282,435 (total savings) = $734,565.

A cost-benefit analysis of this simplified model could be expressed as cost per life saved, cost per year of life saved prior to retirement, and cost per year of life lost prior to age 80 (see Table 8).

Although the cost and benefits of business sponsored mammographic screening programs have not been analyzed in the literature, Carter (1987) reported on a mammography program in a Health Maintenance Organization in Washington state. Using a screening questionnaire to quantify an individual's risk of developing breast cancer, clients are screened yearly, every three years, every five years, or on referral according to their risk level. The cost of a mammogram is estimated to be $26.50.

The number of mammograms performed per year are approximately one fourth of those done if clients were mammogramed every other year from ages 40 to 49 and every year after age 50, as has been recommended by some U.S. groups.

Savings derived from a reduction in cost of treatment of earlier stages of breast cancer are greater than the costs of the mammography program, yielding a net monetary savings to the Health Maintenance Organization. A similar mammography program could be suggested by companies who utilize Health Maintenance Organizations as their primary health provider.

CONCLUSION

Decision analysis and cost effectiveness estimates allow one to evaluate costs and effects of mammographic screening applied to a particular population. An increase in mammographic screening will decrease mortality from breast cancer. In addition to saving lives, mammography will reduce morbidity associated with more extensive treatment required for advanced cancers and will reduce cost of treatment, cost of replacement of employees, days absent from work, and disability payments.

Finally, by detecting breast cancer at earlier and more treatable stages, the suffering of women with breast cancer can be substantially reduced. The example of decision analysis applied to mammographic screening serves as an introduction to the process of cost-benefit analysis. It is hoped that decision analysis and cost-benefit modeling will help health planners as they design and institute mammography programs.

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8-7

GENERAL MOTORS CANCER RESEARCH FOUNDATION PRIZES

CHARLES F. KETTERING PRIZE

Determining the Efficacy of Breast Cancer Screening

SAM SHAPIRO

IT IS NOW WELL ACCEPTED that breast cancer screening in which mammography has a major role can result in substantial reductions in breast cancer mortality—about 30% over a 10-year period after screening starts and 25% over the long run of 18 years. This is the picture that emerges from the randomized controlled trial at the Health Insurance Plan (HIP) of Greater New York to test the efficacy of periodic screening with mammography and clinical examination of the breast. Research in other countries is supporting the basic results of the HIP trial.

The HIP study began in 1963 and ended 23 years later, in 1986. From a researcher's standpoint, 23 years is a long time because of change independent of the intervention that might obscure experimental effects. Unfortunately, a current assessment of the problem involving breast cancer mirrors the situation a generation ago. The fact is that, despite changes over the past 30–40 years in social and economic conditions, nutritional status, health care, fertility patterns, and other life circumstances, breast cancer still accounts for about a quarter of all cancers diagnosed among women and mortality from breast cancer remains virtually unchanged. The degree to which the unvarying picture masks the presence of counteracting trends, such as increases in incidence and more favorable prognoses for the cases diagnosed or differential changes in age, racial, or economic subgroups needs a great deal more attention. But, regardless of what we learn, the critical need will be to apply measures that can result in reduced mortality.

The possibility that screening for detection of breast cancer would lead to decrease in deaths from this condition is quite an old idea. However, not until it was established that mammography could detect occult breast cancer, principally through the pioneering work done by Dr. Robert Egan, while at the M. D. Anderson Hospital and Tumor Institute, was serious attention given to the development of rigorous research to test the value of screening. In the forefront were my colleague, Dr. Philip Strax, and Dr. Michael Shimkin, then head of the National Cancer Institute's Biometry Branch. Both saw the exceptional opportunity that existed at HIP, a large, comprehensive, prepaid group practice, with a history of successful research, for the conduct of the study and made it possible to move ahead.

Issues of Design for the RCT

Critical decisions in the planning phase shaped the course and content for the duration of the investigation. To cite the most important:

The study needed to be a randomized controlled trial to answer two questions, "whether screening is efficacious" and "how much of an effect it has;" results from prior breast cancer screening programs had been discounted because of the absence of acceptable control groups.

The primary end point needed to be mortality from breast cancer rather than case survival. This would avoid the biases in survival rates that result from lead time gained in case detection through screening and the tendency of screening to detect the more indolent cases (referred to as length biased sampling).

Long-term follow-up was needed to establish whether reduction in breast cancer mortality simply represented a temporary, short-term gain or persisted over the long run. There was no prior experience to guide us on this question.

Sufficient uncertainty existed about the application of mammography under screening conditions to make it necessary to include clinical palpation of the breast with mammography. At the time, there was great pessimism that the natural history of breast cancer could be altered through early detection in a screening program. The issue

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ical care costs as part of its employee benefit package, cost effective analyses such as we have provided may be the most important.

Last to be considered in these pecuniary analyses is the individual. An individual is primarily concerned with those expenses that reduce discretionary income. If she perceives that the cost of the procedure is not excessive compared to the expected gain, it is probable that she will opt for the procedure. It is difficult to predict what women will perceive as a reasonable fee for screening. After all, people play the lottery every day and the odds against any major gain are staggering.

Summary

A cost–benefit analysis clearly shows that the costs for screening a large population of asymptomatic women are well within the cost–benefit range accepted for other areas within the medical care system.

Reduction in cancer deaths is not easy to come by. When a method is available which can achieve this result, every effort should be made to make it available until it can be replaced satisfactorily with a less expensive, equally effective method.

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My name is Terry McGeeney. I am director of the ACCESS Employee Assistance Program, a department of Saint Joseph Medical Center in Wichita, Kansas. I am a recovering alcoholic and have worked in the health care field for over eighteen (18) years.

My father's five (5) brothers died of the same disease. Years ago they worked together in Topeka in a family business called the "McGeeney Tree Service." Alcoholism ravished their business and killed all but one of the brothers. The average age at death for my uncles was fifty four (54); through the years there were numerous admissions to hospitals under various psychiatric and medical diagnosis (never alcoholism); only one (1) ever received treatment for his primary disease (alcoholism) and, consequently, he was sober the last six months of his life. My father does not drink, is active and alert at 75 years of age.

Steve, my younger brother, almost died by his own hand in a drunken rage following lengthy bouts of intoxication and a year in Vietnam; fortunately he entered a treatment center, pursuant to a diagnosis of chemical dependency in 1972, and has remained sober since. He has been an EAP counselor for over ten (10) years now.

The ACCESS EAP, through contractual arrangement, currently offers assistance to 6,000 employees and their family members. A well implemented and administered EAP is designed to hold health care costs down without sacrificing quality in care. Last year our EAP assisted 465 clients with

various personal problems. Eighty seven (87) of these cases were diagnosed as chemically dependent. Approximately 60% of these chemically dependent clients were referred to a self-help group (AA, NA, CA, etc.), 20% to outpatient treatment, and the remaining 20% were admitted to inpatient treatment.

Clients referred to inpatient treatment were directed there only after being assessed carefully and all other options were ruled out. High risk health complications, the inability to stop chemical use, and/or a mental state of being in danger to self or others were included in the screening process. Eighty percent (80%) of our chemically dependent cases were treated without hospitalization. However, there were no realistic, viable options to inpatient treatment for the remaining twenty (20%). It was absolutely vital that they entered a setting with qualified medical and counseling staff for proper treatment of their disease.

The option of inpatient treatment must exist for the diseased alcoholic who meets the appropriate, necessary admission criteria; if services must be altered then consider an adjustment to the length of the inpatient stay not the admission itself.

This disease, which is similar to diabetes in a number of ways, will not just disappear. Certain folks that are diagnosed with chemical dependency must be admitted to the hospital for necessary treatment; just as certain diabetic persons must first be treated on an inpatient basis to help break through life threatening denial and provide

stabilization. Only with accurate diagnosis and responsible referrals can cost containment be effective and lives saved. Denying proper treatment to a specific, diseased population in need, will only enhance tragic loss of life and misappropriated funds for treating symptoms rather than the primary problem.

The difference between "pruning and removal" in the tree business is dramatic; the difference between "trimming and deletion" in health care benefits for alcoholism is devastating.

My name is Larry Mannion. I work in the employee assistance program at Saint Joseph Medical Center in Wichita. I'm also a recovering alcoholic and was director of inpatient alcoholism treatment programs in both Kansas and California.

Treatment for chemically dependent persons, both inpatient and outpatient, is cost effective, for several reasons:

1. Treatment for chemical dependency can be, and frequently is, preventive, inasmuch as the unobstructed course of the disease of chemical dependency often results in major physical complications such as cirrhosis of the liver, pancreatitis, hypertension, and cardiovascular problems which are much more expensive to treat. Put another way: it is false economy to see only the short term and to ignore the long term. The employer who limits or eliminates coverage for chemical dependency treatment will in all probability be paying a great deal more to treat the diseases which are the result of untreated chemical dependency. In short, the disease of chemical dependency cannot be considered in isolation, that is, apart from its role in creating other costly and devastating problems. One person I know was hospitalized six times in a period of four (4) years for different kinds of physical problems resulting from his drinking but was not treated for his alcoholism. Eventually he was treated for alcoholism and has not been hospitalized since. That was 10 years ago.

2. When we talk about the chemically dependent person we

are also talking about his family. Indeed, we cannot talk about the chemically dependent person without at the same time talking about his family. The family, especially the spouse and children, suffer just as much if not more from the effects of untreated chemical dependency. The evidence is abundant that family members suffer from a host of psychosomatic and physical problems which run the gamut from severe depression to serious cardiovascular and gastro-intestinal problems and which in turn route their victims to psychiatric and medical/surgical units and the offices of mental health and medical professionals. Thus the problem is compounded; not only does society pay a heavy price in the form of increasing health insurance utilization and lower productivity - but by denying treatment to the chemically dependent person it also, unwittingly, permits the disease to perpetuate itself in any number of other quises which also in turn contribute to increasing health insurance utilization. Put another way: to treat the chemically dependent person is to treat the family.

There is no question that there have been mistakes and abuse in the chemical dependency treatment field, ranging from inflated costs for treatment to multiple hospitalizations. Fortunately, this is changing. By and large, treatment programs especially medical models, have learned from their mistakes and are now offering a variety of treatment approaches; instead of the standard 28 to 30 day inpatient stay, many treatment programs are now offering

options such as 14 days inpatient followed with four weeks of outpatient treatment, and intensive aftercare treatment, all of which are considerably less expensive than the traditional 28 to 30 day program and which for many people are just as effective. That chemical dependency treatment programs needed to change there is no question. But I think it is important that we not throw the baby out with the bath water.

Kansas AMI

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913-642-4389

February 12, 1990

My name is Howard Snyder, and I'm from Prairie Village. I am appearing today as Past President of the Kansas Alliance For the Mentally Ill, and as a father of a disabled 30 year old son who suffers from Schizophrenia. Kansas AMI is a statewide organization of approximately 400 families and friends of Kansas citizens suffering from mental illness.

Kansas AMI and I were active participants, and strong advocates, in favor of the present mandate for very minimal mental illness treatment coverage during the 1984, 85 and 86 battle to achieve the recognition of the mental illnessess as legitimate insurable disorders. I have attached a copy of a 1986 letter from now Governor Hayden strongly endorsing the mandate. I have no evidence nor any reason to believe that his position has changed. In 1986 you, the legislature, found that the mental illnessess merited insurance coverage, but because of a discriminatory choice by the insurance industry for non coverage, a mandate was necessary. That situation has not changed.

In July of 1987, the Arkansas Court of Appeals in the case of Arkansas Blue Cross-Blue Shield v. Doe rendered a decision that bi-polar (manic depressive) disorder is a physical condition, and therefore eligible for insurance coverage under the physical illness portion of the Doe policy. Instead of moving backward to the old days of discriminatory discouragement of coverage, we should be moving forward to the recognition of the mental illnesses as physically based (which is borne out by research). Therefore, they should be treated the same as diabetes or a gall-bladder disfunction. Some of the best research on Schizophrenia is being done by Dr. Ralph Adams at our own Kansas University.

If the industry is serious about cost containment, it should move vigorously on some of the so called "physical" illness costs. On my right hand are two recent outpatient surgerys which are part of a group of 8 removals of carcinoma skin cancers which was done on 1-30-90. These removals took approximately one hour. On 2-7-90 I received a bill for $900. I have never encountered or heard of any mental illness treatment that costs $900 per hour, or any dollar amount close to that.

In the treatment of the mental illnesses, early intervention is critical. The longer the diseases are untreated, the worse the prognosis for recovery becomes. In the absence of insurance coverage, the typical person will not seek treatment, and the psychiatric symptoms will increase until inpatient treatment is needed. This is the most expensive treatment.

Another area of cost containment which should be analyzed is inpatient vs. outpatient. Currently only $1000 of outpatient per year is allowed while the 30 days of reimburseable inpatient care can cost up to $18000. Inpatient care may be needed, but for many people outpatient can be very effective, if available.

Insurance availability is encouragement to seek needed treatment. Current insurance philosophy encourages treatment of the body, and discourages treatment of control box-the brain. This is analogous to an electrician repairing or replacing the wiring in your house, and leaving an old malfunctioning fuze box to control the system.

Many people are going to have on onset of mental illness-1 in 5 per National Institute of Mental Health statistics. These people will require treatment. If they do not have insurance coverage, and are not independently financially secure, they will end up in the public mental health system paid for by public tax dollars, which we all know are in very short supply. The choice is clear-either partial private support or total tax dollar expenditures. Please oppose the repeal of the mental illness insurance coverage, and in fact, consider the expansion of the present minimal reimbursement to coverage on the same basis as other physical illnesses.

Thank you.

Howard Snyder

MIKE HAYDEN
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Speaker of the House

February 19, 1986

Mr. Howard W. Snyder, President
Kansas Families for Mental Health
4811 West 77th Place
Prairie Village, Kansas 66208

Dear Howard:

Thank you for your letter of support and comments on House Bill 2737, which was sponsored by myself and several other legislators.

I was very happy to endorse the concept of this bill and will do everything I can to see that it gets every consideration.

Thanks again for writing.

Sincerely,

Mike

Mike Hayden
Speaker of the Houses

MH:an