Approved: March 2, 2000
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Rep. Robert Tomlinson at 3:35 p.m. on February 8, 2000 in Room 527-S of the Capitol.

All members were present except: Representative Burroughs

Committee staff present: Dr. Bill Wolff, Research
Ken Wilke, Revisor
Mary Best, Secretary

Conferees appearing before the committee: Kathleen Sebelius, Commissioner, Kansas Insurance Department
John Pepperdine, American Cancer Society

Others attending: See attached Committee Guest List

HB 2562-Life insurance company investments; financial futures contracts,

With the meeting at order Revisor Ken Wilke recapped the balloon concerning **HB 2562** presented to the committee February 3rd of this same year. A copy of the balloon is (Attachment #1) attached hereto and incorporated into the Minutes by reference. Mr.Wilke pointed out, that page three (3) carried the main change. The changed deals with the "aggregate amounts of 10% of the life insurance company's admitted assets as shown on the company's last annual or quarterly report, without the prior written approval of the commissioner of insurance...." The change will be inserted into Section (e), line 43, after the work index. The rest of the changes dealt with changing the section reference letters and line numbers. Page one (1) also dealt with changing number (3) to insert another definition to be used in this section and changing number (3) to number (4). The word to be inserted is "Counterparty". Page two (2), dealt with the insertion of the word "SVO' under number (14) which will also become number (16). All other numbers will change along with page number 1. This same change will continue to page number 3 through lines 5. The last of the changes will take place on page number 4, changing the letters starting with the letter (e) to (f) and continue on through the letter (h).

Upon completion of the explanation of the bill, Chairman Tomlinson, called for the bill to be worked by the committee. Representative Kirk made the motion to accept the balloon and Representative Showalter seconded the motion. Discussion on the part of Representative Myers took place as to whether the Commissioner was of with the language or not. It was confirmed the Insurance Commissioner and Department were in agreement with the language and the vote was put before the committee. The committee voted to accept the balloon. Representative Grant then made the motion to move the bill out as amended for passage, Representative Showalter seconded the motion. A vote was taken from the committee passed the bill out favorably.

HB 2778-providing coverage for secondary consultations in cancer.

With this information before the committee, the Chairman proceeded by opening the public hearing on **HB 2778**. The Chairman recognized Commissioner of the Kansas Insurance Department, Kathleen Sebelius to the floor. Commissioner Sebelius presented Proponent Testimony to the committee. A copy of the testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference.

Commissioner Sebelius gave an overview of the bill which addresses seconds opinions in cancer situations. She stated the bill was before the committee for a variety of reasons. She informed the committee the bill originated as a patient protection package and is in congress now. She stated that many of these plans being offered are already in force right now in several different states, but are not consistent with one another. She informed the committee that the health plans will have front-end costs added to the coverages, coverages that

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are meant to be "preventative medical care, and should significantly reduce long-term costs and increase quality of life."

The Commissioner informed the committee, she had had the issue brought to her attention by Mr. Richard Bloch, a cancer survivor himself. He has been doing a great deal of research and collection of data from many of the top cancer experts in the country. Mr. Bloch's testimony is attached to the Commissioners testimony. It is (Attachment #3) attached hereto and incorporated into the Minutes by reference. It was stated "There is a substantial body of scientific evidence that indicates the cure rated would increase to 75% when good preventive and diagnostic procedures are allowed."

The commissioner stated that the concepts of the bill were simple and designed to save lives by being able to seek out a second opinion from specialists in this field, when there is the likelihood of cancer is present. The bill simply states "....a health plan shall provide reimbursement for a secondary consultation with a specialist, selected by the insured's physician." These same plans could not penalize a specialist financially for giving the patient the diagnosis. The Commissioner stated, "A similar provision was passed by the United Stated Senate in the Patient Protection measure and is pending in conference committee."

The Commissioner feels the issue is about saving money, lives and getting the cancer patient to a specialist as quickly as possible. With this the Commissioner stood for questions. Questions were posed by Representative boston regarding the cost of the increase in rates. The fiscal note which was believed to be in error will be resubmitted to the chair at a later date. The original fiscal note showed a possible no fiscal impact on the general funds. The Commissioner then asked if there would be a direct impact on their own personal budget. Questions were raised regarding second opinions in cancer and not other areas

The changes to the bill would come under amending KSA 1999 Supp. 40-2, 103 and 40-19c09 and repealment of the existing sections. Questions continued with Representative Boston regarding Page 2, line 41. Revisor, Ken Wilke responded, answering this was "standard language on mandates." Representative Empson then questioned the limits on consultations and whether or not MRI's, CTSCAN's, etc. would also be included. Representative Kirk addressed drafting errors to which the Commissioner directed attention to the balloon.

With no further questions the Chair then recognized Mr. John Pepperdine, American Cancer Society, who also gave Proponent Testimony to the committee. A copy of the written testimony is (Attachment #4) attached hereto and incorporated into the Minutes by reference. Mr. Pepperdine stated that the Cancer Society supported the bill and that the ultimate decision should by between the doctor and patient. He also stated that most people are not aware of the need/ability to obtain a second opinion. He stated that managed care companies just help on these issues except for fiscal results. Question was asked by Representative Showalter.

The next conferee to be recognized was Mr. Bill Sneed, Health Insurance Association of America. Mr. Sneed offered Opponent Testimony to the committee. A copy of his written testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference. Mr. Sneed informed the committee Kansas law does not disallow anyone from getting a second opinion. Th problem is **who** will pay for it? Much of Mr. Sneed's testimony provided information on his clients position relative to mandates. Mr. Sneed also provided information based on a study entitled *The Price of State Mandated Benefits,* by Jon Gabel and Gail A. Jensen. It was stated, in 1989, "states had passed more than 700 mandates, most of which required insurers to cover specific diseases or to pay for the services of certain types of providers." It also stated that through these studies it was determined mandates raised insurance coverage rates, discouraged small businesses from providing coverage, and encouraged firms to self insure. Further results of the study were included in Mr. Sneeds' handout. Mr. Sneeds handout also included other information on mandates and how they affect the insurance market and the policyholders.

Questions were asked by Representatives Kirk, Boston and Grant, covering second opinions, exact language of each situation, and benefit packages designed by the employer.

Larry Ann Lower, Kansas Association of Health Plans, was the next conferee to be recognized by the Chairman. Ms Lower presented Opponent Testimony to the committee. A copy of the testimony is

(Attachment #6) attached hereto and incorporated into the Minutes by reference. Ms. Lower and her clients were in opposition to further mandates put on insurance providers, especially those for full coverage for "secondary consultations with a specialist chosen by the attending physician to confirm or refute the positive or negative diagnosis of cancer at no additional cost to the consumer." Ms. Lower stated they have three (3) distinct concerns: (1) The terms "full coverage"and "at no additional costs." Are carriers being forced to disregard any and all copays and/or any deductibles when there is a second consultation? (2) How many "second opinions are going to be allowed, and (3) "...the attending physician can select any specialist regardless of whether the specialist is a participating network provider?"

Ms. Lower requested the committee allow the providers to "meet the demands of the marketplace rather than enacting an unclear mandate that may inadvertently cause the cost of health insurance to rise." With this Ms. Lower stood for questions. Questions were presented by Representative Kirk, Empson and the Chairman.

Mr. Terry Leatherman, Kansas Chamber of Commerce and Industry, presented written Opponent Testimony only to the committee. Mr. Leatherman basically agreed with the former conferees. A copy of Mr. Leathermans' testimony is (Attachment #7) attached hereto and incorporated into the Minutes by reference.

The Chair called for further discussions or testimonies on the bill. With none the public hearings were closed.

HB 2770-Insurance; providing coverage for diagnosis and treatment of osteoporosis.

The Chair recognized Insurance Commissioner Kathleen Sebelius. The commissioner gave an overview of bill stating the bill "is to provide insurance coverage to individuals with a condition or medical history for which bone mass measurement (bone density testing) is determined to be medically necessary for the individual's diagnosis and treatment of osteoporosis." A copy of the testimony and analysis is (Attachments #7&8) attached hereto and incorporated into the Minutes by reference. The Commissioner presented an amendment to KSA 1999 Supp. 40-19c09 and 40-2,103. In the new section the act would be known as the "bone measurement coverage act." She then explained the new sections 2 and 3 with the changes to sections 4, 5 with repeals to section 6. Section 7 would hold the effective date: Statute book. An analysis of the bill regarding whether or not health care insurers in Kansas provide coverage for bone density testing was attached. The Commissioner then stood for questions.

The Chairman again addressed the fiscal note. He requested another note. Questions continued regarding numbers of people this bill would cover that were not already covered, who determines who qualified physicians are, to the cost of these tests. Asking questions beside the Chair were, Representatives Boston, Kirk.

Opponents to the bill were then recognized. Mr. Bill Sneed, Health Insurance Association of America, gave Opponent Testimony. A copy of the testimony is (Attachment #9) attached hereto and incorporated into the Minutes by reference. Mr. Sneed again addressed mandates being passed down to companies. Mr. Sneed was unaware of any company among his clients that did not already cover bone density tests and/or the diagnosis and treatment of osteoporosis. Mr. Sneed also addressed lines 18-19 which carried the term "medically necessary." He stated to their knowledge, "all insurance contracts under the purview of the Kansas Insurance Department require coverage for "medically necessary" testing and/or treatment." Mr. Sneed's clients feel this may be a requirement for a bone density test "regardless of a physician's determination of medical necessity." These are service mandates already in Kansas Laws. They also felt that if this is the case they had not seen any documentation that a mandate such as this would be cost effective in today's marketplace. Mr. Sneed stood for questions. As there were none the Chair recognized Larry Ann Lower.

Ms. Lower, Kansas Association of Health Plans, gave Opponent Testimony to the committee. A copy of the testimony is (Attachment #10) attached hereto and incorporated into the Minutes by reference. Ms. Lower explained Managed Health Care to the committee and that the survey of her HMO's showed they are all currently providing coverage for bone density testing if the individual has a condition, medical history or is over menopause and testing is determined medically necessary. Mr. Lower and her clients feel that before any further mandates are passed that the new legislation be subject to the provisions of K.S.A. 1999 Supp. 40-2249a. Which requires testing of any new mandates, on the state employees health plan to determine the

cost impact. Ms. Lower stood for questions. Questions were raised by Representatives Kirk, Toelkes and Boston.

The Chair requested any further discussions on this bill. As there were none the public discussions on this bill were closed. With no further business, the meeting was adjourned. Time is 5:21 p.m.

The next meeting will be held February 10th of this year. The meeting will be moved to Room 519-S.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: 2/8/00

NAME	REPRESENTING
Bill Sneed	HIAA
Rich Gottshie	Health Midwest
Tim McConville	Federico Consulting
Larrie Ann Lower	KAHP
Pat Morris	KAIA
Connie Donovan	KAIA
John Pepperdine	ACS
Kevin Davis	Am. Family Ins.
Chip Wheelen	Osteopathic Association
Danielle Noe	Dof A

Session of 2000

HOUSE BILL No. 2652

By Committee on Insurance

1-19

9 AN ACT concerning insurance; relating to life insurance company in-
10 vestments; financial futures contracts; amending K.S.A. 1999 Supp. 40-
11 2b25 and repealing the existing section.
12
13 *Be it enacted by the Legislature of the State of Kansas:*
14 Section 1. K.S.A. 1999 Supp. 40-2b25 is hereby amended to read as
15 follows: 40-2b25. (a) Any life insurance company heretofore or hereafter
16 organized under any law of this state may use financial instruments under
17 this section to engage in hedging transactions and certain income gen-
18 eration transactions or as these terms may be further defined in regula-
19 tions promulgated by the commissioner. The life insurance company shall
20 be able to demonstrate to the commissioner the intended hedging char-
21 acteristics and the ongoing effectiveness of the financial instrument trans-
22 action or combination of the transactions through cash flow testing or
23 other appropriate analysis.
24 (b) As used in this section:
25 (1) "Cap" means an agreement obligating the seller to make pay-
26 ments to the buyer, each payment based on the amount by which a ref-
27 erence price or level or the performance or value of one or more under-
28 lying interest exceeds a predetermined number, sometimes called the
29 strike rate or price.
30 (2) "Collar" means an agreement to receive payments as the buyer
31 of an option, cap or floor and to make payments as the seller of a different
32 option, cap or floor.

(3) 'Counterparty' means the business entity with which a life insurance company enters into financial instrument transactions.

33 ~~(3)~~ (4) *"Crediting basis amount" means the amount of interest credited*
34 *to an insured's account value for the percentage of change on an under-*
35 *lying index.*
36 ~~(3)~~ ~~(4)~~ (5) (A) "Financial instrument" means an agreement, option, in-
37 strument or any series or combination thereof:
38 (i) To make or take delivery of, or assume or relinquish, a specified
39 amount of one or more underlying interests, or to make a cash settlement
40 in lieu thereof; or
41 (ii) which has a price, performance, value or cash flow based primarily
42 upon the actual or expected price, level, performance, value or cash flow
43 of one or more underlying interests.

(B) Financial instruments include options, warrants, caps, floors, collars, swaps, forwards, future and any other agreements, options or instruments substantially similar thereto, or any series or combination thereo

(6) ~~(4)~~ ~~(5)~~ "Financial instrument transaction" means a transaction involving the use of one or more financial instruments.

(7) ~~(5)~~ ~~(6)~~ "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount that a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance or value of one or more underlying interests.

(8) ~~(6)~~ ~~(7)~~ "Forward" means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

(9) ~~(7)~~ ~~(8)~~ "Future" means an agreement traded on a qualified exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

(10) ~~(8)~~ ~~(9)~~ "Hedging transaction" means a financial instrument transaction which is entered into and maintained to reduce:

(A) The risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) the currency exchange-rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred or anticipates acquiring or incurring.

(11) ~~(9)~~ ~~(10)~~ "Income generation transaction" means a financial instrument transaction involving the writing of covered call options which is intended to generate income or enhance return.

(12) ~~(10)~~ ~~(11)~~ "Option" means an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

(13) ~~(11)~~ ~~(12)~~ "Potential exposure" means:

(A) As to a futures position, the amount of the initial margin required for that position; or

(B) as to swaps, collars and forwards, .5% times the notional amount times the square root of the remaining years to maturity.

(14) 'SVO' means the securities valuation office of the National Association of Insurance Commissioners or any successor office established by the National Association of Insurance Commissioners.

(15) ~~(12)~~ ~~(13)~~ "Swap" means an agreement to exchange for net payments at one or more times based on the actual or expected price, level, performance or value of one or more underlying interests.

(16) ~~(14)~~ *"Underlying index" means the index, market or financial futures contract used to determine the crediting basis amount.*

(17) ~~(13)~~ ~~(15)~~ "Underlying interest" means the assets, other interests, or a combination thereof, underlying a financial instrument, such as any one or more securities, currencies, rates, indices, commodities or financial instruments.

(18) ~~(14)~~ ~~(16)~~ "Warrants" means an option to purchase or sell the underlying securities or investments at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another corporation.

(c) A life insurance company may enter into financial instrument transactions for the purpose of hedging except that the transaction shall not cause any of the following limits to be exceeded:

(1) The aggregate statement value of options, caps, floors and warrants not attached to any other security or investment purchase in hedging transactions may not exceed 110% of the excess of such insurer's capital and surplus as shown on the company's last annual or quarterly report filed with the commissioner of insurance over the minimum requirements of a new stock or mutual company to qualify for a certificate of authority to write the kind of insurance which the insurer is authorized to write;

(2) the aggregate statement value of options, caps and floors written in hedging transactions may not exceed 3% of the life insurance company's admitted assets; and

(3) the aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions may not exceed 5% of the life insurance company's admitted assets.

(d) A life insurance company may enter into the following types of income generation transactions if:

(1) Selling covered call options on noncallable fixed income securities or financial instruments based on fixed income securities, but the aggregate statement value of assets subject to call during the complete term of the call options sold, plus the face value of fixed income securities underlying any financial instrument subject to call, may not exceed 10% of the life insurance company's admitted assets; and

(2) selling covered call options on equity securities, if the life insurance company holds in its portfolio the equity securities subject to call during the complete term of the call option sold.

(e) The limitations set forth in subsection (c) regarding financial instrument transactions for the purpose of hedging and in subsection (d) regarding income generation transactions shall not apply to any investments made by a life insurance company where such investments are used only to hedge the crediting basis amount an insured receives on a particular insurance policy which is determined by an underlying index

provided, however, that such investments shall not in the aggregate amount exceed 10% of the life insurance company's admitted assets as shown on the company's last annual or quarterly report, without the prior written approval of the commissioner of insurance. All investments made pursuant to this subsection shall only be made with counterparties that have a rating designated as "1" by the national association of insurance commissioners (NAIC) in its most recently published valuations of securities manual or supplement thereto, or its equivalent rating by a nationally recognized statistical rating organization recognized by the SVO.

~~(e)~~ *(f)* Upon request of the life insurance company, the commissioner may approve additional transactions involving the use of financial instruments in excess of the limits of subsection (c) or for other risk management purposes, excluding replication transactions, pursuant to regulations promulgated by the commissioner.

~~(f)~~ *(g)* For the purposes of this section, the value or amount of an investment acquired or held under this section, unless otherwise specified in this code, shall be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the ~~national association of insurance commissioners (~~NAIC~~)~~, including the purposes and procedures of the securities valuation office, the valuation of securities manual, the accounting practices and procedures manual, the annual statement instructions or any successor valuation procedures officially adopted by the NAIC.

~~(g)~~ *(h)* Prior to engaging in transactions in financial instruments, an insurer shall develop and adequately document policies and procedures regarding investment strategies and objectives, recordkeeping needs and reporting matters. Such policies and procedures shall address authorized investments, investment limitations, authorization and approval procedures, accounting and reporting procedures and controls and shall provide for review of activity in financial instruments by the insurer's board of directors or such board's designee.

Recordkeeping systems must be sufficiently detailed to permit internal auditors and insurance department examiners to determine whether operating personnel have acted in accordance with established policies and procedures, as provided in this section. Insurer records must identify for each transaction the related financial instruments contracts.

Sec. 2. K.S.A. 1999 Supp. 40-2b25 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: HB 2778 – Coverage for secondary consultations

DATE: February 8, 2000

Mr. Chairman and members of the committee:

Thank you for the opportunity to appear today. I want to set a framework for the bills we will discuss today, as well as the other three patient protection issues which will come before the Committee later this week.

All of these issues have been implemented in some other states, and most are contained in either the House or Senate versions of the pending Patient Protection legislation in Congress. Many health plans already provide the coverage outlined in these measures, but the coverage is not consistent. While an argument can (and will) be made that these features add front-end costs to health plans, all of these coverages are aimed at best practices and preventive medical care, and should significantly reduce long-term costs and increase quality of life. In the case of the bill you will hear today, the measure should actually save lives.

The issue was brought to my attention by Richard Bloch, co-founder and honorary Chairman of H&R Bloch, who is a cancer survivor and has spent his own time and money on a significant cancer foundation in Kansas City. Mr Bloch has worked with thousands of patients around the country, and collected data

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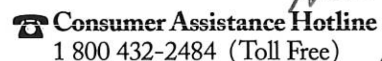

2-1

and opinions from the top cancer experts in the country. He has also served on the national Cancer Advisory Board for 6 years. I am only sorry that he is not able to be with us today. But I'd like to share some of his sentiments with you.

Cancer is a major health issue for Kansans and Americans, and the treatment and understanding about the disease is changing rapidly. The National Cancer Institute has stated that if physicians would use the recommended treatments, it is estimated that about 10% of the deaths could be avoided each year. There is a substantial body of scientific evidence that indicates the cure rates would increase to 75% when good preventive and diagnostic procedures are followed.

The May, 1999, issue of Oncology News International states: "Cancer remains a devastating disease that causes more than 1/2million deaths a year in this country alone, a number that will rise as the population ages...By the year 2000, cancer will consume 15 to 20% of all US healthcare dollars, or about $200 billion a year."

The concept in the bill is relatively simple and is designed to save lives, by seeking second opinions from specialists where a diagnosis or likelihood of cancer exists. The bill states that a health plan shall provide reimbursement for a secondary consultation with a specialist, selected by the insured's physician. Also, health plans could not financially penalize a specialist for providing the consultation. A similar provision was passed by the United States Senate in the Patient Protection measure and is pending in conference committee.

I agree with Mr. Bloch. The issue is about saving lives and saving dollars, by getting cancer patients to a trained specialist as quickly as possible, for the proper treatment and to give the patient informed options. I would urge the Committee to favorable consider this legislation.

Bill Summary: HB 2778

SYNOPSIS: An act concerning health insurance; providing coverage for secondary consultation in cancer cases; amending KSA 1999 Supp. 40-2,103 and 40-19c09 and repealing the existing sections.

SECTION 1:

a. Any company, HMO, etc. providing health coverage issued, amended, or renewed on or after January 1, 2001, which provides coverage for medical / surgical services relating to diagnosis of cancer shall also provide full coverage for secondary consultations with specialists in appropriate medical fields, including (but not limited to) pathology, radiology, and oncology.

1. coverage shall be provided regardless of whether such secondary consultation is based on positive or negative initial diagnosis of cancer

2. coverage shall provide for (at no extra charge) consultation with any specialist selected by attending physician of the insured or the insured's dependent, regardless of whether such physician is a participating provider

3. no individual or group health insurance policy, medical service plan, contract, etc. providing health insurance coverage required by this subsection shall penalize, etc. or limit the reimbursement of a provider or specialist because such provider or specialist provided care to an insured in accordance with this section

4. the provisions of this subsection shall not be construed as requiring the provision of secondary consultations where the insured patient determines not to seek such a consultation

b. any provision in any individual or group insurance policy, medical service plan, contract, etc. which provides coverage for medical / surgical benefits in relation to the diagnosis of cancer which is delivered, issued, etc. on or after January 1, 2001, that is in conflict with this section shall be of no force and effect.

c. the provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident-only coverage, credit, dental, etc. etc. as defined by KSA 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, etc. under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

SECTION 2 KSA 1999 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103 deals with the application of statutes (used for an individual who resides or is employed in the state).

SECTION 3 KSA 1999 Supp. 40-19c09 is hereby amended to read as follows:

a. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the KSA, applicable to nonprofit corporations, etc. etc.

b. No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision that which excludes, limits or otherwise restricts coverage because of Medicaid benefits as permitted by title XIX of the social security act of 1965, etc.

c. Violation of subsection (b) shall be subject to the penalties prescribed by KSA 40-2407 and 40-19c09 are hereby repealed

Section 4. Repealer section

Section 5. Effective date: Statute book

Amendment needed:

Session of 2000

HOUSE BILL No. 2778

By Committee on Insurance

2-1

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10 AN ACT concerning health insurance; providing coverage for secondary
11 consultation in cancer cases; amending K.S.A. 1999 Supp. 40-2,103
12 and 40-19c09 and repealing the existing sections.
13
14 ***Be it enacted by the Legislature of the State of Kansas:***
15 New Section 1. (a) Any individual or group health insurance policy,
16 medical service plan, contract, hospital service corporation contract, hos-
17 pital and medical service corporation contract, fraternal benefit society
18 or health maintenance organization which provides coverage for mental
19 health benefits and which is delivered, issued for delivery, amended or
20 renewed on or after January 1, 2001, which provides coverage for medical
21 and surgical services in relation to the diagnosis of cancer also shall pro-
22 vide full coverage for secondary consultations with specialists in appro-
23 priate medical fields, including, but not limited to, pathology, radiology
24 and oncology, to confirm or refute such diagnosis. In addition:
25 (1) The coverage required by this subsection for such secondary con-
26 sultation shall be provided regardless of whether such secondary consul-
27 tation is based on a positive or negative initial diagnosis of cancer.
28 (2) The coverage provided by this section shall provide for~~, at no~~
~~**29** additional cost to the insured, consultation with any specialist selected by~~
~~**30** the attending physician of the insured or the insured's dependent, re-~~
~~**31** gardless of whether or not such specialist is a participating provider~~.
32 (3) No individual or group health insurance policy, medical service

~~mental~~

such secondary consultation, if such services are not sufficiently available from specialists operating under the plan. The health plan or insurer shall ensure that such coverage is provided at no additional cost to the insured beyond that which the insured would have paid if the specialist was participating the network of the health plan.

A. BLOCH CANCER FOUNDATION, INC.
4435 Main Street, Suite 500-Kansas City, MO 64111-Phone: 816-932-8400 Fax: 816-931-7486
E-mail - vrich@hrblock com website - www.blochcancer.org

February 7, 2000

To the esteemed members of the Kansas Legislature:

I thank Commissioner Kathleen Sebelius for presenting my thoughts to you. I am sorry I am unable to attend and speak directly to you. In 1978, I was told I had lung cancer with only three months to live. I was told to go home and get my estate in order. I was devastated, who wouldn't be? Almost ready to accept my fate I was encouraged by friends to seek other opinions. Luckily, I listened and I found my treatment at a comprehensive cancer center in Houston. After two years of aggressive therapy, I was told I was cured. I made a promise to the doctors that cured me - I promised I would work to help others with cancer fight this dreaded disease. I sold my interest in H & R Block, Inc. - a tax preparation business that my brother Henry and I started in 1955. In 1982, I retired from the company and since that time my wife Annette and I have focused our attention on working "to help the next person who gets cancer."

From the moment we set up our foundation, we realized that the most important thing we could give the newly diagnosed cancer patient and family was hope. Hope that there would be a system set up to offer them a prompt diagnosis and a timely and successful treatment. We, at the foundation, are constantly working on programs that meet that need. We have started a National Hot Line where a newly diagnosed cancer patient can speak to a cancer survivor of their type and receive encouragement and support from someone that has been there and survived. What does that mean to someone who has been given a death sentence? It means the cancer patient will be given hope that they too can also become survivors.

The foundation has also asked doctors to participate in panels that would offer a Multidisciplinary Second Opinion to the patient and family. Ideally, these panels take place 7-10 days following initial diagnosis. Present would be a medical oncologist, radiation oncologist and surgeon (unless their specialty is not applicable in treating the diagnosed type of cancer). The purpose of this type of second opinion is to honestly inform the patient of all their options and to assist in forming the best plan to successfully treat the disease.

When we speak to newly diagnosed cancer patients we always ask if they have received a second opinion. Most often the response is no. Many times we are told that their doctors say they don't need one or that nothing else can be done. We at the foundation do not believe that is an informed decision. The patient is entitled to make an informed decision. We also know that there isn't a doctor in the world that would not seek a second or third opinion when faced with the diagnosis of cancer or any other fatal disease. Why shouldn't the general public be allotted the same consideration? Why wouldn't a doctor want the very best for his or her patient? Why wouldn't a second opinion outside of a doctors own medical group be encouraged?

Our goal is to reduce cancer mortality with what we know today! Cancer is a unique disease - if you don't treat it properly the first time, often there is no second chance. It is an extremely complex disease, generally requiring treatment by multiple specialists. An oncologist rarely diagnoses it. The initial physician often fails to give the best possible treatment.

Hopefully, your goal will also be to save lives so I strongly urge you to give prayerful consideration to Commissioner Sebelius' proposal. This action will not only save lives, it will reduce the pain and suffering patients and their families and friends go through. It will also improve the quality of life for all cancer patients because they will know they got the best treatment the first time.

Respectfully yours,
Richard Bloch

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February 8, 2000

testimony by John Pepperdine
Manager of Government Relations

SUPPORT OF HOUSE BILL 2778 UNDER REVIEW BY THE KANSAS HOUSE INSURANCE COMMITTEE

As the largest voluntary health organization dedicated to improving cancer care, the American Cancer Society urges support of such legislation that would help ensure patients', especially those affected by cancer, choice of provider and continuity of care. This bill is an important step forward in improving patients' access to the types of providers best suited to provide their care.

More than 140 million insured Americans are in some kind of managed care plan and this includes many of the approximately 1.23 million people diagnosed with cancer each year. In addition, the National Cancer Institute estimates that 8 million Americans alive today have a history of cancer. Managed care offers coordinated care for prevention, early detection, and treatment of cancer, as well as health promotion programs. However, this system has a tendency to be driven by cost containment rather than improvement of patient outcomes.

Studies have shown that specialists do make a difference. As part of a broader national patient protection legislative agenda, the American Cancer Society has been advocating a provision to ensure that managed care patients with serious or life threatening illness have access to specialists, including continuity of care, standing referrals, and selection of a specialist as the primary care provider. The Society advocates providing access to specialty care environments (such as centers of excellence or community cancer center) that have adequate resources, personnel with training, expertise, and experience to provide high quality care in diagnosing and treating cancer.

We particularly appreciate your recognition of the special needs of people with serious illnesses, such as skin cancer, and those of people with life threatening illnesses. Cancer patients in both of these categories often experience tremendous difficulties when they are forced to obtain referrals for ongoing care by a specialist or when they are forced to change providers in the midst of their treatment. Continuity of care is also important to patients whose cancer is in remission. Your legislation will help remove some of the very large obstacles these patients face in receiving appropriate treatment and follow up for their illness.

Again, we applaud any effort to ensure that private insurance patients have their choice of provider and are assured continuity of care. We look forward to working with you this year on the advancement of meaningful, patient protection legislation that safeguards cancer patients, cancer survivors, and all patients with serious or life threatening diseases.

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Memorandum

TO: The Honorable Bob Tomlinson, Chairman
House Insurance Committee

FROM: William W. Sneed, Legislative Counsel
Health Insurance Association of America

RE: H.B. 2778

DATE: February 8, 2000

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent the Health Insurance Association of America ("HIAA"). HIAA is the nation's leading advocate for the private, market-based health care system. Our 255 plus members provide health insurance to approximately 110,000,000 Americans. We appreciate this opportunity to provide comments on H.B. 2778. After reviewing the bill, we appear today in opposition to its passage.

Much of this testimony will provide my client's position relative to mandates in general as it relates to health insurance in the commercial insurance arena. However, before providing that information, we would like to comment on specific provisions of H.B. 2778.

This bill appears to provide "full coverage" for a secondary consultation as it relates to the diagnosis of cancer. The bill also requires coverage regardless of a positive or negative initial diagnosis. We have some difficulty in ascertaining why, if an initial diagnosis is negative, a second consultation would be necessary.

Secondly, the bill provides the ability for consultation with <u>any</u> specialist at "no additional cost," regardless of whether such a specialist is a participating provider. My client would argue that such a provision could in essence destroy a provider network, and ultimately increase

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overall costs for every insured. One may use the phrase "no additional cost," but in reality these costs will be borne by additional premiums.

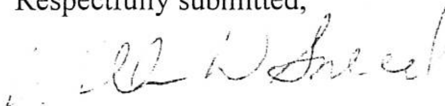
Ironically, the law then goes on to state that this proposal should not be construed to require a provision of secondary consultation where the insured determines not to seek such a consultation. What we are uncertain about is what this particular language will do for managed care situations.

Finally, no insurance policy, or state law, prohibits anyone from seeking a second consultation. In fact, you can go and get a second consultation for any illness and/or diagnosis, not just for the diagnosis of cancer. What is at issue is whether or not the second consultation should be covered by your insurance policy. Ultimately, if such coverages are required, they will be imputed into the rate base and paid for by policyholders.

As stated earlier, my client opposes mandated benefit laws for a variety of reasons. Attached to my testimony is a study prepared by Dr. Gail A. Jensen and Dr. Michael A. Morrisey regarding mandated benefit laws and employer-sponsored health insurance. We believe the attached documentation demonstrates that notwithstanding the fact that some mandated benefit has a good "sound bite," in reality such mandates are cost drivers and can have the opposite affect in the marketplace.

Based upon the foregoing, my client urges the Committee to reject H.B. 2778. Thank you very much for the opportunity to provide testimony, and if you have any questions, please feel free to contact me.

Respectfully submitted,



William W. Sneed

Attachments: 1

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HIAA

Health Insurance Association of America

Mandated Benefit Laws and Employer-Sponsored Health Insurance

Gail A. Jensen, Ph.D.
Department of Economics and Institute of Gerontology
Wayne State University

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5-3

Preface

In 1989, the Health Insurance Association of America (HIAA) published a study entitled *The Price of State Mandated Benefits*, co-authored by Jon Gabel and Gail A. Jensen. At that time, states had passed more than 700 mandates, most of which required insurers to cover specific diseases or to pay for the services of certain types of providers. The study concluded that mandates raised the price of insurance coverage, discouraged small businesses from providing coverage, and encouraged firms to self-insure. A decade later, HIAA decided to reexamine these issues, although changes in patterns of insurance regulation meant that we would now be examining the effect of federal as well as state mandates.

HIAA again commissioned Gail A. Jensen, Ph.D., of the Department of Economics and Institute of Gerontology, Wayne State University, and Michael A. Morrisey, Ph.D., of the Lister Hill Center for Health Policy, University of Alabama-Birmingham (who had contributed econometric work to the prior study), and asked them to examine the cost and consequences of benefit mandates.

The following are highlights of their study:

- One in five to one in four uninsured Americans lacks coverage because of benefit mandates.
- The number of state mandates increased at least 25-fold between 1970 and 1996.
- Workers pay for mandated benefits in the form of reduced wages or fewer benefits, as well as higher insurance premiums.
- As the number of benefit mandates increases, the cost of coverage rises, and as costs rise, more and more firms seek to self-insure to avoid the added expenses imposed by mandates.
- Given that ERISA preempts self-insured firms from state mandates, the passage of such mandates will not lead to substantially more people with a given benefit. Indeed, a state mandate that applies to private group plans will cover, on average, only 33 percent of a state's population, whereas one that applies to all private group plans and individually purchased policies will cover about 42 percent of a state's population.
- Smaller firms are disproportionately affected by mandates in part because they are less likely than larger firms to be able to avoid the costs of mandates by self-insuring. This, in turn, implies that, because health insurance will be more expensive for smaller firms (because they must include the new benefit), they will be less likely to offer coverage to employees.
- Mandates cost money. In Virginia, mandates accounted for 21 percent of health insurance claims; in Maryland, they accounted for 11 to 22 percent of claims; and in Massachusetts, 13 percent of claims.

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- Several benefits are particularly expensive. Chemical dependency treatment coverage increases a plan's premium by 9 percent on average; coverage for a psychiatric hospital stay increases it by 13 percent; coverage for visits to a psychologist increases it by 12 percent; and coverage for routine dental services raised premiums by 15 percent.

The proliferation of mandated benefits has increased the cost of health insurance, disproportionately hurting employees who work for small businesses. But benefit mandates enjoy tremendous political popularity, and serve frequently as central items on the campaign platforms of candidates running for political office. While individually, such benefit mandates may be hotly supported by certain interest groups, the cumulative effect has had a measurably detrimental impact on the ability of Americans to afford health insurance coverage. Policy makers, then, need to be aware that what is politically expedient may come with a high price tag as well as clearly foreseeable harmful consequences for health care consumers.

INTRODUCTION

Currently, well over 1,000 coverage mandates are in place across the country; and state and federal lawmakers give every indication of increasing their involvement in group insurance markets. State legislatures and Congress have passed a wide variety of mandates. Some require that particular types of providers or particular services be covered. Others deal with the guaranteed issue and renewal of policies, waiting periods, and the treatment of pre-existing conditions. More recently, some specify a minimum number of covered hospital days following certain medical procedures, or deal with the nature of the provider networks that managed care firms can establish.

While proponents of these laws believe that they enhance insurance coverage and improve the quality of care, mandates have been shown to increase premiums, and to cause declines in wages (and other fringe benefits); worse yet, mandates lead some workers and employers to forgo insurance coverage altogether. Furthermore, the cost of mandates falls disproportionately on workers in smaller firms, those least able to bear this burden.

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Current Scope of Group Insurance Regulation

Both the states and the federal government have enacted requirements for the content of health plans. But there are far more state laws than federal. These state laws include "conventional" mandatory-inclusion and mandatory-option laws that specify particular providers, services, and/or subscriber cohorts, as well as mandates relating to: (1) small-group reform laws, (2) specifics of coverage laws, and (3) provider network laws. (See Table 1.)

Most Common State Mandates in 1996

Required Coverage	Number of States with Mandates	Number Requiring Mandatory Inclusion	Number Requiring Mandatory Option
Provider Mandates			
Chiropractors	41	39	2
Psychologists	41	40	1
Optometrists	37	35	2
Dentists	34	35	1
Benefit Mandates			
Mammography Screening	46	42	3
Alcoholism Treatment	43	27	16
Maternity Length-of-Stay	34	34	0
Mental Health Care	32	18	14
Extension Mandates			
Conversion to Non-Group Policy	39	38	1
Continuation Coverage for Employees	38	37	1
Continuation Coverage for Dependents	35	34	1
Handicapped Dependents	34	34	0

Source: Blue Cross Blue Shield Association (1997).
Note: Only laws applying to all insurers were counted.

TABLE 1

Federal statutes affect the applicability of state insurance laws. The Employee Retirement Income Security Act (ERISA) effectively exempts self-insured firms from state insurance regulations. Nearly half (46 percent) of all covered workers are now in self-insured plans [Jensen et al. 1997] that are not subject to state insurance laws. Moreover, the federal HMO Act of 1973 and its amendments of 1988 appear to exempt federally qualified HMOs from some state mandated benefits, although, as Butler [1996] notes, the exemption provision of the HMO Act has yet to be tested in the courts. Many HMOs are federally qualified, and the majority of HMO subscribers are in federally qualified plans.

State Mandates

State governments have been regulating the terms of private health plan coverage by means of mandates for over three decades. These laws initially consisted of mandatory-inclusion provisions. If insurance policies were sold in the state, they had to include coverage for the mandated provider type, service, or subscriber cohort, such as adopted children. Over time, the types of services and providers covered under state mandates for private health plans have grown.

Until the 1970s, nearly all state mandates were mandatory-inclusion laws. Mandatory-option laws began to appear in the early 1970s. The latter require that the insurer offer coverage for particular types of providers or services. Employers, however, have the option of not purchasing this additional coverage.

The trend in conventional mandates enacted across all the states since 1970 is illustrated in Figure 1. The number of state mandates increased at least 25-fold between 1970 and 1996. In 41 benefit areas alone, the number of mandates rose from 35 in 1970 to 860 in 1996.

States vary considerably in their philosophies towards mandates, as indicated by Figure 2. Some states, such as Delaware, Idaho, and Wyoming, have enacted relatively few conventional mandates, while others, such as California, Connecticut, Florida, and New York, have passed more than 25. By and large, states with the most mandates were the ones that got an early start enacting them.

In the late 1980s and early 1990s, states began to legislate newer forms of insurance mandates, attempting to improve the small-group market by specifying particular service obligations within coverages, and delineating the nature of managed care networks.

The extent to which small-group reform statutes were enacted is summarized in Table 2. These mandates typically focused on guaranteed issue and guaranteed renewal, portability of coverage, pre-existing condition clauses, and premium rating restrictions. By 1995, 45 states had enacted one or another of these sets of laws; 36 had enacted them all [Hing and Jensen 1998].

Mandates in the 1990s have included provisions dealing with the coverages offered by managed care plans. Some 19 states currently establish a standard definition of the need for emergency room care. Hospital length-of-stay mandates, which now exist in 35 states, establish minimums for hospital care coverage following certain medical procedures. Gag rules prohibit clauses in the provider contracts of managed care plans that might restrict communication between patients and their physicians; a majority of states (39) now have them [EBRI 1998].

Most states have also enacted one or more laws to regulate the nature of the provider panels created by managed care firms. The best known of these are the any willing provider (AWP) and freedom of choice (FOC) laws, but they also include direct-access laws that allow subscribers to use specific types of in-network specialists without first obtaining a referral from the primary care physician.

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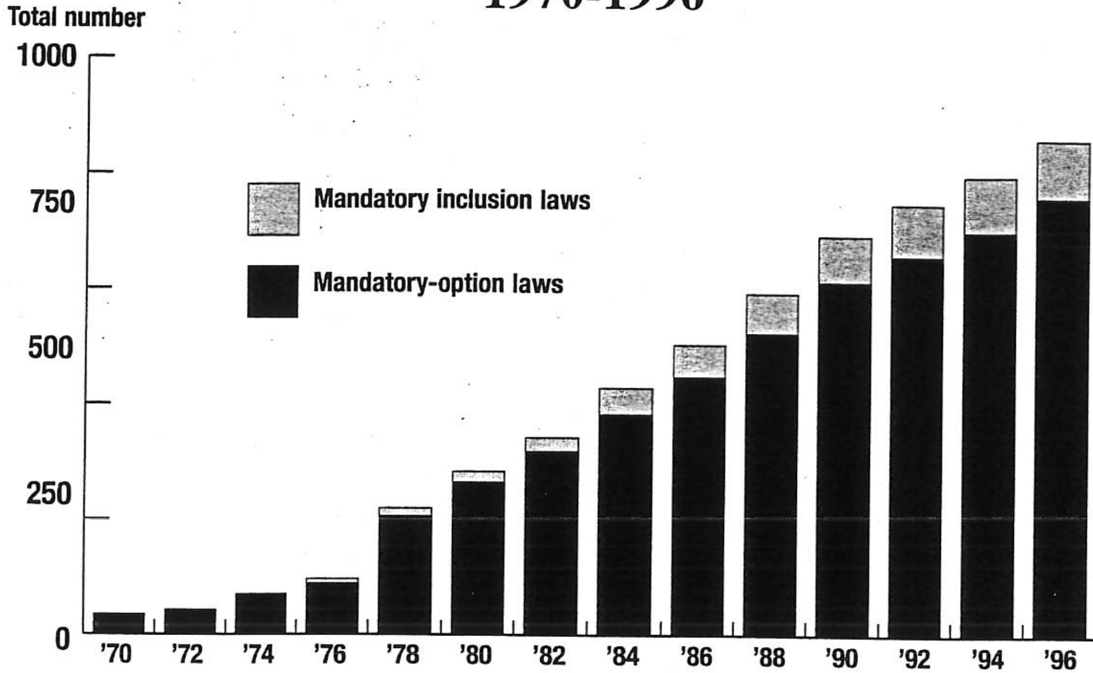
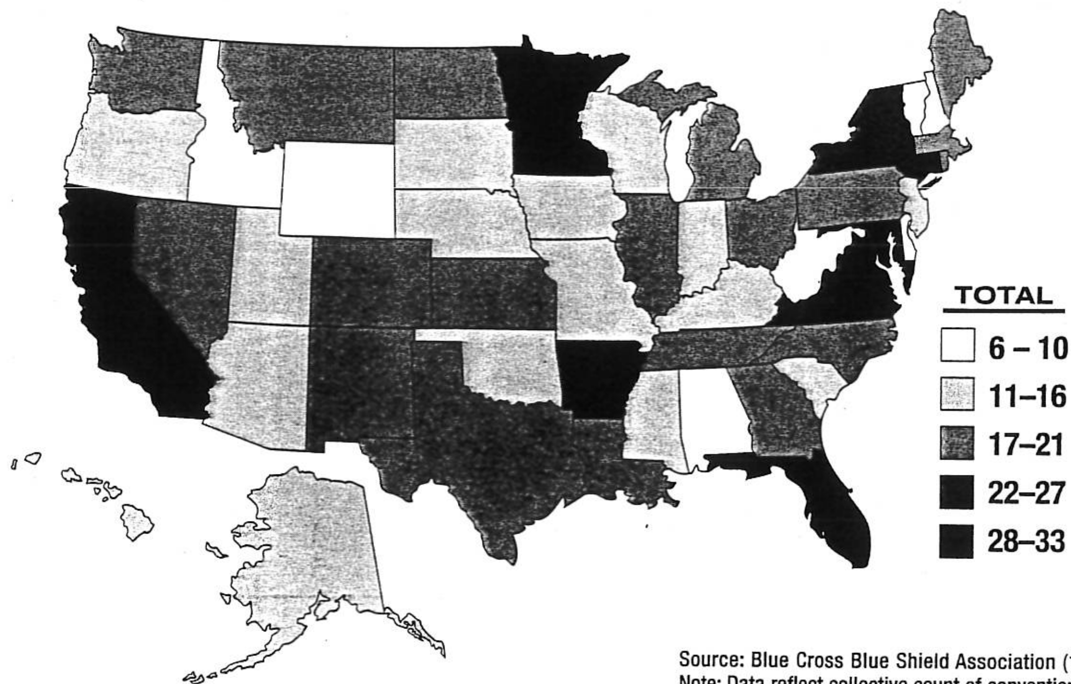


Source: Blue Cross Blue Shield Association (1997)
Note: Data reflect collective count of conventional mandates across all states, which pertain to 41 aspects of plan coverage.

FIGURE 1

Conventional Mandated Benefits by State, 1996



Source: Blue Cross Blue Shield Association (1997)
Note: Data reflect collective count of conventional mandates across all states, which pertain to 41 aspects of plan coverage.

FIGURE 2

5-100

State Small Group Insurance Reforms

Type of Measure	Number of States Which Had Enacted the Measure as of: 1989	1991	1993	1995
Mandate-Waiver Plans Can be Sold	1	9	31	43
Guaranteed Issue Requirements	0	5	30	38
Guaranteed Renewal Requirements	1	18	40	43
Portability of Coverage Requirements	3	16	40	43
Limits on Waiting Periods for Coverage of Pre-existing Conditions	11	25	43	45
Premium Rating Restrictions	1	20	42	45

Source: Jensen and Morrisey (1999).

TABLE 2

States with Alternative AWP and FOC Laws

	Provider Covered:		
	Physician	Hospital	Pharmacy
Any Willing Provider Laws:			
HMO			
1989	5	3	7
1995	11	9	25
PPO			
1989	7	3	7
1995	11	7	22
Freedom of Choice Laws:			
HMO			
1989	3	4	4
1995	5	5	16
PPO			
1989	4	4	6
1995	6	5	18

Source: Calculated from Ohsfeldt et al. (1998).

TABLE 3

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The growth and extent of AWP and FOC laws is summarized in Table 3. AWP laws require managed care plans to allow any provider to be included in the network if he or she is willing to abide by the terms and conditions of the network contract. FOC laws require that a managed care subscriber be allowed to step outside the network and obtain services from any licensed provider as long as the subscriber pays a larger amount out-of-pocket. The laws are complex in their application. Some apply only to HMOs, others only to PPOs, but often they apply to both. Laws covering pharmacies were the most common, although AWP laws applicable to physicians existed in 11 states.

Direct access mandates are FOC laws with a twist. They allow subscribers to bypass their physician gatekeepers to see certain types of specialists, but those specialists must be network providers. More than half the states (29) now mandate direct access to obstetricians-gynecologists, and a few mandate direct access to network dermatologists, ophthalmologists, psychiatrists, or chiropractors [EBRI 1998].

Federal Mandates

Whether purchased or self-insured, all plans are subject to several federal mandates, including the 1978 Pregnancy Discrimination Act, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the 1996 Health Insurance Portability and Accountability Act (HIPAA), the 1996 Mental Health Parity Act, the 1996 Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act of 1998.

With the exception of the recent mental health benefit mandates, the existing federal laws are of the mandatory-inclusion variety. The mental health parity requirements, however, are similar to the newer state mandates that specify specific conditions of service (if the benefit is provided). Moreover, most of the federal mandates were preceded by a large number of state mandates in these same areas of coverage. In most cases, the federal laws represent new mandates for only a minority of states.

The federal mandates are significant in two respects, however. First, they directly amend ERISA to apply to self-insured plans as well as purchased products. Second, they may be a harbinger of the "federalization" of health insurance regulation.

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Why Choose to Mandate?

Why have the states and the federal government passed so many laws regulating health insurance? One view of benefit mandates is that they spring from a widespread desire to correct inefficient or inequitable market practices. This so-called "public interest" view holds that health insurance mandates are designed to correct problems in the health care market. Mandates are viewed as an attempt to provide access to coverage or specific treatment practices valued by subscribers but withheld by employers or insurers.

The alternative view of legislation is that the laws and regulations stem from an attempt by self-interested parties to further their private interests. This "public choice" view holds that the passage of insurance mandates is driven by providers of clinical services who want to increase the demand for their services or thwart the ability of their rivals to achieve a competitive advantage. Passage of mandates may also be driven by patient advocacy groups (e.g., those representing persons needing certain services) who want to lower the out-of-pocket costs for certain services. By requiring coverage of the service, its net price is reduced, and so more people utilize the service. In general, proponents of mandates are special interest groups that stand to personally benefit from the laws

As for legislators, they trade their support for mandates for political support—votes, publicity, campaign contributions—from core constituencies that have a stake in the enactment of a mandate. Thus, legislative benefits accrue to relatively small groups of people who are deeply committed to a particular issue. Costs, on the other hand, are spread across a broad majority. Thus, proposed legislation would generally have a very large, direct financial impact on providers or suppliers of goods or services, while the impact on purchasers would be diffused over a much larger group of individuals.

Providers also find it easier to organize than would consumers in general. As a result, the primary proponents and opponents of legislation tend to be providers or suppliers, whose gains or losses are large enough to warrant the costs of political action. In the health care field, provider groups have been the primary proponents of legislation.

The direct evidence with respect to the enactment of insurance mandates is thin but is generally consistent with the view that the laws reflect provider efforts. There is a much wider literature on health legislation that reaches the same general conclusion.

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The Economics of Mandates and Employer-Sponsored Health Insurance

Most people who purchase health insurance in the United States do so through their employer. Workers value health insurance, and it is less expensive when purchased through an employer than when purchased individually. There are three reasons for this. First, federal and state tax codes do not treat health insurance as taxable income. Second, employed individuals are generally healthier than those who are not, and are therefore likely to file fewer claims and have lower costs. Finally, administrative costs on a per-individual basis are lower when coverage is purchased through an employer.

People generally are paid what they are worth. Strictly speaking, they are paid the value of the output they produce. Workers can be paid in a variety of ways: wages; wages and a pension; wages, health insurance, and parking; and so on. However, the total cost of the compensation package can't exceed the value of the worker to the firm. If health insurance is to be part of the compensation package, some other element of the package must be reduced.

Employers will offer health insurance only if workers value it. Workers must give up wages or other benefits in return for the health insurance coverage. If they don't value the coverage, they might be better off working for a firm that offers only wages (or other benefits that workers value more).

Economics suggests that employers will offer health insurance plans that are valued by their workers, with coverages that reflect the preferences of the employees. If not, employers will have to compensate by raising wages or other benefit levels, or the workers may become dissatisfied and decide to work elsewhere.

Given all this, the economics of insurance mandates are straightforward. Suppose a new coverage, say for eyeglasses, is mandated in all plans. Obviously, if a firm already offers the coverage, then the mandate has no effect on that employer. Labor and insurance market effects occur only when the mandate requires coverage that employers don't offer voluntarily because workers don't place a high value on it.

The new coverage will raise the cost of insurance. The labor market will adjust to reflect the additional cost. Wages may be reduced to pay for the new benefit, or other, non-mandated benefits may be eliminated. In a smoothly functioning labor market, workers necessarily bear the cost in one form or another. They now have to pay for an eyeglasses benefit that they previously didn't value enough to pay for. This is the first consequence of a mandate: Wages, other health benefits, or non-health benefits will be reduced to pay for the new coverage.

Proponents of mandated benefits argue that the new coverage benefits workers. But this "benefit" comes with higher premiums. The burden of the mandate to workers, then, is the cost of the coverage over and above what they were willing to pay for it in the absence of a mandate.

It may be that workers will find the new insurance/wage package unattractive. This will lead them to look for an employer that does not offer the new coverage, or to find an employer that does not offer health insurance at all.

This leads to the second consequence of mandates: Employees will have an incentive to seek out firms that do not offer coverage, or to drop coverage entirely, if the cost to them of the mandate is sufficiently high.

The employer has another option to try to mitigate the effect of the mandate. ERISA exempts self-insured plans from the reach of state insurance laws. This is the third consequence of mandates: Firms will seek to become self-insured to avoid the costs of the mandated coverage faced by their workers.

The ability to self-insure under ERISA has other implications for labor and insurance markets. This leads to the fourth consequence of mandates: In the presence of ERISA, a state mandate will not necessarily lead to substantially more people with the covered benefit. Many will be excluded by virtue of coverage through self-insured plans, and others will move to self-insured firms. (More federal mandates would effectively deny such firms some of the advantages of self-insuring.)

Self-insurance is not equally costly for all employers. When a firm self-insures, it becomes its own risk pool. Insurance risk declines as the size of the insurance pool grows. Therefore, smaller employers will face more risk in self-insuring than will larger firms. Thus, the fifth consequence of mandates is: Small employers will be disproportionately affected by virtue of being less able to avoid the mandate by self-insuring. This, in turn, implies that health insurance will be more expensive for small firms (because they must include the new benefit), and they will be more likely not to offer insurance. They will also tend to attract workers who value insurance coverage the least. Obviously, federal mandates are likely to have greater implications for the wage-benefit trade-off than state mandates because the federal mandates apply to self-insured plans as well.

These employer-labor market effects apply to all mandatory-inclusion laws. Mandatory-option laws have decidedly fewer effects because the firm is free to include or exclude the coverages as it chooses.

Laws that apply to only one type of insurer have additional effects because they change the attractiveness of one type of plan relative to another. AWP or FOC laws or gag rules that apply only to PPOs, for example, will raise premiums for PPOs relative to conventional plans, HMOs, and point-of-service plans. This is the final consequence of the economics of mandates: Laws that restrict only particular types of plans will reduce the attractiveness of those plans.

Evidence of the Effects of Mandates

Who Is Affected by Mandates?

Most federal mandates cover all group health plans, whether self-insured or purchased, but some exclude certain plans from compliance. Sixty-one percent of Americans are covered by private group health insurance, and the majority of these people are entitled to most federally mandated benefits. (Medicare, Medicaid, and other government plans, as well as individually purchased policies, are excluded from compliance with most federal mandates. Some federal mandates, such as COBRA and the Mental Health Parity Act, also exclude small employers.)

In contrast, under a state mandate, a large majority of a state's population is unaffected because the laws apply only to purchased conventional, PPO, and POS plans, and HMOs. A state mandate does not cover persons who lack employer coverage to begin with; who are covered only by Medicare, Medicaid, or another government program; or who are covered by a self-insured group plan. A state mandate that applies to private group plans will cover, on average, only 33 percent of a state's population, whereas one that applies to all private group plans and individually purchased policies will cover about 42 percent of a state's population.

The numbers are low for several reasons. First, 30 percent of the population has Medicare, Medicaid, some other public coverage, or no coverage at all. These people are not subject to state mandates. Second, even among persons who have private coverage (70 percent), most of this coverage is beyond the reach of state laws. Nine percent have individual coverage. While state laws specify the nature of these individual insurance policies, they are typically not affected by group mandates.

Further, among all persons with private group coverage in 1995 (61 percent), 63 percent of conventional plan enrollees, 60 percent of PPO plan enrollees, 53 percent of POS plan enrollees, and 10 percent of HMO enrollees were in self-insured plans.

Of the 33 to 42 percent of persons in plans subject to state mandates, only those who were not already receiving the benefit gain access to it as a result of a new mandate law. These people are typically workers and their families participating in plans offered by smaller firms. This is because most small-firm coverage is insured (and thus subject to state mandates), and because insurance benefits offered by small firms tend not to be as rich as those offered by large firms [Jensen et al. 1997].

Of course, any failure to enforce state mandates would reduce their effectiveness even further. Thus, while one might assume that state mandates affect the preponderance of a state's population, in reality the opposite is closer to the truth. Less than half of a state's population is in plans affected by state mandates.

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Employers' Experiences with Adverse Selection Under COBRA, 1990–1996

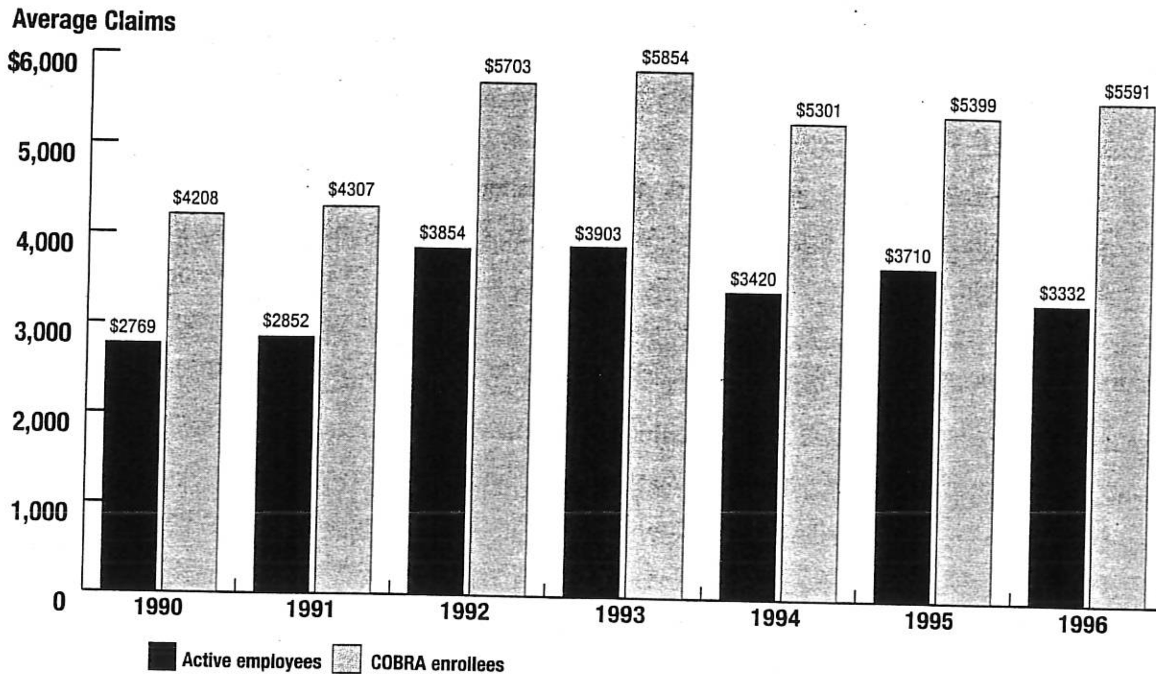

FIGURE 3

Source: Stephen A. Huth, COBRA Costs Continue to Be High, Erratic, *Employee Benefit Plan Review*, September 1997, 36–44.

What Do Mandates Cost?

The full costs of mandated benefits include not only the additional premiums, but also the consequent changes in access to health insurance, the nature of coverage, workers' compensation, and possibly even a firm's hiring practices.

In this section, however, our focus is on the more narrow notion of costs, namely, the extra premiums due to mandated coverages. These are important in their own right because it is the consequent changes in the cost of insurance that give rise to costs in other arenas. If premium increases are negligible, we can expect few other costs, whereas if they are large, other costs, too, are likely to be substantial.

In the case of state mandates, data on insurance claims in a state can be used to calculate the share of insurance claims associated with mandates. Using this method, mandated benefits in Virginia were found to account for 21 percent of claims; in Maryland, 11 to 22 percent of claims; in Massachusetts, 13 percent of claims; in Idaho, 5 percent of claims; and in Iowa, 5 percent of claims.

These estimates, however, are not a measure of the premium cost of mandates. The full share of claims cannot be attributed to mandates because some of the coverages likely would have been provided anyway. The more appro-

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priate measure is the "marginal cost" of mandates, which is the difference between actual costs and the costs that would have resulted without the mandates. Using a nationwide cross-section of insured firms in 1989, Acs et al. [1992] found that mandates significantly raised premiums. Among firms that offered health insurance, premiums were found to be 4 to 13 percent higher as a direct result of state mandated benefits.

Jensen and Morrisey [1990] provided information on the marginal cost of including specific types of coverage based on the actual experience of plans, which is also useful in gauging the cost of mandates. Several benefits, which many states have mandated, were found to be expensive. Chemical dependency treatment coverage increased a plan's premium by 9 percent on average. Coverage for a psychiatric hospital stay increased it by 13 percent. Adding benefits for psychologists' visits increased it by 12 percent, and adding benefits for routine dental services increased it by 15 percent. These estimates may slightly overstate the cost to an employer of complying with a new mandate in one of these areas because the sample of firms used in the study offered very generous benefits all around, and may have offered better coverage than a state would typically prescribe. The estimates nonetheless suggest that mandates can be expensive for firms that otherwise would not offer these coverages.

A survey conducted each spring by Charles D. Spencer & Associates, Inc., covering 1.4 million workers in approximately 200 firms, has consistently found that persons who elect COBRA coverage cost much more to insure than active workers. Average claims per COBRA enrollee in 1996, for example, were 68 percent higher than average claims per active worker ($5,591 vs. $3,332) [Huth 1997]. This is not a one-time finding, but rather one that has held up for years. (See Figure 3.) Workers, through their employers, are clearly paying a huge subsidy for each continuation enrollee, and such adverse selection is bound to raise group premiums. Since COBRA enrollees on average comprise 2.2 percent of all plan enrollees [Huth 1997], premiums per normal enrollee are 4 percent higher than they would be were it not for the COBRA mandate.

COBRA also imposes administrative costs on a firm, including the costs of communicating continuation rights to eligible individuals, collecting premiums from these enrollees, and, in some cases, monitoring their right to continued eligibility. Although probably small in relation to incremental premiums, the administrative costs are still significant. Estimates for 1990, for example, were in the range of $150 to $240 annually per COBRA enrollee [Charles D. Spencer & Associates, Inc., 1990].

Are Wages Reduced as a Result of Mandates?

A key result of the economics of employer-sponsored health insurance is that workers pay for the coverage in the form of reduced wages or fewer benefits.

Recent research on workers' compensation insurance suggests that wages are lower in the presence of other benefits. These studies are particularly important because, like health insurance mandates, workers' compensation coverage is mandated by state law. In these studies, researchers were able to carefully account for the size of the benefits received if a person were injured, and they used particularly good measures of the risk of injury. Gruber and Krueger [1991] found that over 86 percent of the costs associated with workers' compensation were borne by workers in the form of lower wages. Viscusi and Moore [1987] concluded that all the costs were borne by workers.

The only study examining the effects of health insurance mandates on workers' wages is that of Gruber [1994]. He examined the effects of state maternity mandates implemented in 1976-1977 in Illinois, New Jersey, and New York, prior to the federal mandate. His results indicated that the full cost of the mandates was paid by women ages 20 to 40. The difference in wages of married women ages 20 to 40, for example, was 4.3 percent lower in Illinois, New Jersey, and New York after the mandate than they were for similar women in the control states over the same period. This is dramatic evidence that workers pay for the cost of mandates in the form of lower wages.

Do Some Workers Lose Coverage as a Result of Mandates?

If mandates increase the cost of coverage, it is possible that some buyers, whether firms or individuals, will decide that health insurance simply isn't worth it, in which case the number of purchasers will decline.

Using data from 1989 to 1994, Sloan and Conover [1998] found that the higher the number of coverage requirements placed on plans, the higher the probability that an individual was uninsured, and the lower the probability of people having any private coverage, including group coverage. The probability that an adult was uninsured rose significantly with each mandate present. Because their analysis had exceptionally high statistical power—it included more than 100,000 observations—these findings are quite persuasive.

These results suggest that eliminating benefit mandates entirely would reduce the proportion of uninsured adults by approximately four percentage points, i.e., from 18 to 14 percent of the non-elderly population. This implies that one-fifth to one-quarter of the uninsured problem is due to the presence of state mandates. The study's findings confirm those of an earlier study by Goodman and Musgrave [1987], who estimated that, in 1986, 14 percent of the uninsured nationwide lacked coverage because of mandates.

Have Mandates Encouraged Firms to Self-Insure?

Since ERISA exempts self-insured plans from state regulation, it is conceivable that state-mandated benefits have spurred some firms to self-insure as a way of avoiding coverage requirements. The importance of mandates in self-insurance decisions has been the subject of several studies. Jensen et al. [1995] estimated the impact of state mandatory-inclusion mandates on the decisions of mid- to large-sized firms (50 or more workers) to convert to self-insurance during the early and mid-1980s. Most mandated benefits had a positive but statistically insignificant effect on the likelihood of conversion. Even when considered collectively, mandates did not explain conversions to self-insurance that occurred between 1981 and 1984/85, nor those that occurred between 1984 and 1987.

Greater premium taxation of purchased plans, however, was found to strongly encourage self-insurance. Both premium taxes and state risk-pool taxes were found to have significant effects on the likelihood of converting. Between 1981 and 1984/85, the presence of a state continuation-of-coverage requirement also encouraged self-insurance but was not a factor for the later period examined. One interpretation is that when COBRA took effect in early 1986, self-insurance was no longer a way to avoid offering continuation rights. As noted earlier, continuation benefits have been found to raise premiums substantially (e.g., by 4 percent).

Do Mandates Disproportionately Affect Small Firms?

Mandates have increased the uninsured population, priced some small firms out of the group market altogether, and forced workers to go uninsured or buy coverage on their own. Jensen and Morrisey [forthcoming] document the effects of the laws on small firm coverage over the 1989–1995 period for firms with fewer than 50 workers. Each additional mandate significantly lowered their probability of offering health insurance. The findings suggest that eliminating all mandates would have raised the proportion of small firms that offered coverage by 9.4 percentage points, or from 49 percent to 58.3 percent. Small firms that would sponsor coverage, were it not for the presence of mandates, comprise 18 percent of all uninsured small businesses.

In an earlier study [1992], Jensen and Gabel examined the separate effects of different types of benefit mandates on small firms' decisions to offer coverage. Although most individual mandates had negligible effects, Jensen and Gabel found that, even in the mid-1980s, state mandates accounted for 19 percent of non-coverage among small firms. The most troublesome mandates were state continuation-of-coverage rules. These pre-COBRA state mandates allowed terminated workers to buy into the firm's plan. Continuation mandates have been found to give rise to acute adverse selection and, hence, to raise premiums. This finding suggests that, in small firms, which typically have high worker turnover, these effects may be especially severe.

However, Uccello [1996] and Jensen and Morrisey [forthcoming] found that small firms were no less likely to offer coverage in states with pre-existing condition mandates. One explanation is that problems with insurer restrictions on the coverage of pre-existing conditions were never widespread to begin with, so the laws, in effect, were "non-binding" limits. Indeed, for years the coverage of pre-existing conditions in the small-group market has been about the same as in the large-group market [Jensen and Morrisey 1998].

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CONCLUSIONS

Four conclusions emerge. First, both conventional mandates specifying coverage for particular provider types and services, and newer mandates affecting small-employer markets and managed care plans have expanded dramatically at the state level during the 1980s and 1990s. Federal laws regulating the nature of health coverage have also grown. While many of the federal measures have tended to mimic similar state laws already in place, the federal laws potentially have a larger impact because they affect the coverage of the approximately 43 percent of workers who are enrolled in self-insured plans. Moreover, it appears that health insurance legislation may be becoming federalized as Congress considers even more coverage mandates.

Second, most state mandates affect less than half of the state's population. Thus, state efforts to increase access to particular benefits can have only limited success. Moreover, the effect of the laws falls disproportionately on workers in small firms because these firms are less able to self-insure and avoid the consequences of the mandates.

Third, mandated benefit laws do have negative effects. This is particularly true of the conventional mandates that have required inclusion of specific benefit provisions. Recent work indicates that a fifth to a quarter of the uninsured have no coverage because of state mandates. Federal mandates are likely to have even larger effects.

Finally, and perhaps most important, workers pay for health insurance mandates in the form of reduced wages or fewer benefits. If insurance plans are required to expand benefits or remove cost-containment devices, premiums rise. Workers and their employers may be able to avoid some of these costs by switching to less desirable plans or by self-insuring. To the extent that they cannot, wages or other forms of compensation must fall.

Mandates are attractive. Their proponents argue that they guarantee access to particular coverages, expand benefits, and enhance quality. More than that, they are off-budget. The costs don't appear as explicit items in state or federal budgets. However, mandates are not free. They are paid for by workers and their dependents, who receive lower wages or lose coverage altogether.

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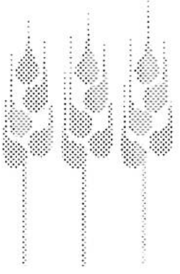

Kansas Association of Health Plans

Testimony before the
House Insurance Committee
The Honorable Robert Tomlinson, Chairman
Hearings on HB 2778
February 8, 2000

Chairman Tomlinson and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and others who support managed care. KAHP members serve many of the Kansans enrolled in an HMO.

The KAHP appears today in opposition to HB 2778. This bill mandates that a health insurer must provide full coverage for secondary consultations with any specialist selected by the attending physician to confirm or refute the positive or negative diagnosis of cancer at no additional cost to the consumer.

We have three distinct concerns with this mandate: First, the "full coverage" and "at no additional cost" portions of the bill are not clear to us. Generally a health insurance policy has certain deductibles and copays that are included in a contract for coverage. Does this bill force carriers to disregard deductibles and copays for the second consultation?

Second, the consultation may be obtained whether the initial diagnosis was a positive or negative diagnosis. This may cause insureds to automatically seek a second opinion every time a diagnosis is negative. Our final concern with this bill is that the attending physician can select any specialist regardless of whether the specialist is a participating network provider.

You are going to find during the next couple of days that my testimony may seem repetitive, and I apologize for repeating the same thoughts, however the importance of what I say should not be minimized due to repetitiveness. On HB 2778, of the HMO's responding to my survey, all currently offer a second opinion on a diagnosis of cancer. However, the majority of the plans, in an attempt to hold down the cost of health insurance require that the insured seek a second consultation from a network provider. In the event there is not a network

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specialist available insureds are allowed to go to an out of network provider. The insured is subject to the same copays and deductibles provided in the contract for coverage. This second consult is allowed not because the government has demanded that we allow the second consultation, but because this is what the marketplace has demanded of us.

In conclusion, the KAHP would request that you continue to allow us to meet the demands of the marketplace rather than enacting an unclear mandate that may inadvertently cause the cost of health insurance to rise. If the goal is to devise a one-size fits all coverage, then we are getting closer and closer to accomplishing that goal. The ability to provide a choice in types and expense of health insurance plans is becoming less and less with each new mandate passed.

Finally, if you feel this is a necessary mandate then we would strongly suggest that this legislation first be subject to the provisions of K.S.A. 1999 Supp. 40-2249a. This statute, which you passed last year, requires the testing of any new mandate first on the state employees health plan in order to determine its cost impact. I will be happy to try to answer any questions the committee may have.

LEGISLATIVE TESTIMONY

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HB 2778 February 8, 2000

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Insurance

by

Terry Leatherman
Vice President – Legislative Affairs

Mr. Chairman and members of the Committee:

My name is Terry Leatherman. I am the Vice President of Legislative Affairs for the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to express KCCI's opposition to passage of HB 2778.

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 2,000 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 48% of KCCI's members having less than 25 employees, and 78% 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.

It is hard to find an insurance mandate initiative that lacks merit or emotional appeal. That is certainly the case with HB 2778. However, as this Committee certainly understands, if passing HB 2778 negatively impacts the cost of insurance, it will not be insurance companies who will pay these

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hig costs. Instead, the cost will be passed along to all Kansans who receive their insurance through policies governed by state law.

Those affected by insurance mandates are people insured in small groups and individual policies. These are also the people who have the hardest time finding affordable insurance. That is why the Kansas Chamber has consistently opposed insurance mandate legislation in recent years. The net result of new mandated insurance coverage is to make insurance more expensive, which drives more Kansans to choose not to purchase health insurance.

KCCI would also question the additional intrusion of government into the private insurance market, which would happen if HB 2778 becomes law. Insurance is a private sector contractual arrangement. The elements that make up an insurance product should be developed to meet the needs of consumers by insurance companies, not lawmakers.

Thank you for considering the Kansas Chamber's concerns regarding HB 2778.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Kathleen Sebelius, Commissioner of Insurance

RE: HB 2770 – Guarantees coverage of bone density testing for diagnosis and treatment of osteoporosis

DATE: February 8, 2000

Mr. Chairman and members of the committee:

Thank you for the opportunity to discuss with you HB 2770. The purpose of this bill is provide insurance coverage to individuals with a condition or medical history for which bone mass measurement (bone density testing) is determined to be medically necessary for the individual's diagnosis and treatment of osteoporosis.

Osteoporosis is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased susceptibility to fractures of the hip, spine, and wrist. Osteoporosis is a major public health threat for more than 28 million Americans, 80 percent of whom are women. Today, 10 million individuals (8 million women and 2 million men) already have the disease and 19 more have low bone mass, placing them at increased risk. And, while osteoporosis is often thought of as an older person's disease, it can strike at any age.

It is estimated that one out of two women and one in eight men over age 50 will have an osteoporosis-related fracture in their lifetime. Osteoporosis is responsible for more than 1.5 million fractures annually. The cost projection on a national basis is estimated at $13.8 billion ($38 million each day).

Osteoporosis is often called the "silent disease" because bone loss occurs without symptoms. Individuals will not know they have the disease until their weak bones collapse. Certain people are more likely develop osteoporosis than others, and "risk factors" have been identified to include the following: just being female; having a family

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history; thin or small body frame; postmenopause, including early menopause; low testosterone levels in men; advanced age.

Through specialized tests called bone density tests, detection can be made of osteoporosis before a facture occurs; or predict your chances of fracturing in the future; or determine your rate of bone loss. While there is no cure for osteoporosis, a comprehensive program can help prevent osteoporosis. It includes: a balanced diet rich in calcium and vitamin D; weight-bearing exercise; a health lifestyle (no smoking and limited alcohol intake), and bone density testing and medication when appropriate.

Medical experts agree that osteoporosis is highly preventable. But, they also agree that it is reasonable to project that the future for definitive treatment and prevention of osteoporosis is bright.

As indicated in an analysis of whether or not health care insurers in Kansas provide the coverage provided for in HB 2770 – coverage for bone density testing in the diagnosis and treatment of osteoporosis – some plans provide coverage, but only as a follow-up or treatment of an already diagnosed case. Others provide the coverage discussed in HB 2770. I am asking for the passage of HB 2770 to make sure all health insurance companies and plans provide coverage. In the impact study required by K.S.A. 40-2248 and 40-2249, the companies or plans have already indicated that use of the bone density testing for diagnosis and treatment would not have a significant increase in their premiums, and in fact, the impact would be minimal. The diagnosis and treatment of osteoporosis, like the foresight of the legislature when it passed prostate cancer screening, is one of the cases where paying costs in prevention and early detection, reduce the costs of extenuating circumstances later.

Mr. Chairman, I respectfully ask your favorable consideration of HB 2770.

Bill Summary: HB 2770

SYNOPSIS: An act concerning health insurance; providing coverage for osteoporosis; amending KSA 1999 Supp. 40-2,103 and 40-19c09 and repealing the existing sections.

NEW SECTION 1: This act shall be known as the "bone measurement coverage act"

NEW SECTION 2: The purpose of this act is to provide insurance coverage to persons with a condition or medical history for which bone mass measurement (bone density testing) is determined to be medically necessary for the individual's diagnosis and treatment of osteoporosis.

NEW SECTION 3:

a. any individual or group health insurance policy, medical service plan, contract, hospital service corp., etc. which provides coverage for accident and health services and which is delivered, issued for delivery, etc. on or after January 1, 2001, shall provide coverage for any qualified individuals for the diagnosis and treatment of osteoporosis

b. for the purpose of this section:

1. "bone marrow measurement" means a radiologic or radioisotopic procedure or other scientifically proven technologies performed on an individual for identifying bone mass or detecting bone loss.

2. "qualified individual" means a person with a condition for which bone mass measurement is determined to be medically necessary by the person's attending physician or primary care physician.

c. the provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, etc. as defined by KSA 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, or any insurance etc. under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

SECTION 4: KSA 1999 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103, - application of statutes.

SECTION 5: KSA 1999 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09

a. corporations under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code,
b. no policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits, restricts coverage because Medicaid benefits as permitted by title XIX of the 1965 social security act.

c. violation of subsection (b) shall be subject to the penalties prescribed by KSA 40-2407 and 40-2411 and amendments thereto.

SECTION 6 - Repealer section. KSA subsection 1999 Supp. 40-2,103 and 40-19c09 are hereby repealed.

SECTION 7 - Effective date: Statute book

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Fungal

Oral		*Topical*	
$	nystatin*	$	Mycolog-II*
$$	Fulvicin U/F	$	Mycostatin*
$$	Fulvicin P/G	$$	Lotrimin*
$$$$$$	Lamisil	$$	Oxistat
Vaginal		$$$	Exelderm
$	nystatin vaginal*	$$$	Lotrisone
$$	Vagistat		

OSTEOPOROSIS ESTROGEN REPLACEMENT (#)

$	Estrace*	$$$	Estraderm, Vivelle
$$	Premarin Products		

PAIN

Narcotics/Non-Narcotics		**NSAIDs**	
Oral		$	aspirin* **otc**
$	acetaminophen/ codeine*	$	ibuprofen*
		$	indomethacin*
$	Phrenilin, Phrenilin Forte	$$	naproxen*
$	Hydrocet*	$$	naproxen sodium*
$	propoxyphene nap/ acetaminophen*	$$	piroxicam*
		$$	Salflex*
$$$	Dilaudid	$$	sulindac*
$$$	MSIR	$$$	Daypro
$$$$$	MS Contin	$$$$	Children's Advil
$$$$$	OxyContin	$$$$	Lodine
$$$$$	Toradol		

SKIN PROBLEMS

$	hydrocortisone* **otc**	$$$	Elocon
$	betamethasone valerate*	$$$	Eurax
		$$$	Halog, Halog-E
$	Kenalog*	$$$	Lac-Hydrin
$$	Diprosone*, Maxivate	$$$	Metrogel
$$$	Aclovate	$$$	Temovate E Gel
$$$	Cutivate	$$$	Ultravate
$$$	Dovonex	$$$	Westcort
$$$$	Diprolene, Diprolene AF	$$$$$	Condylox
		$$$$$$	Accutane

SLEEP AIDS

$	diphenhydramine* **otc**	$$$	Ambien
$	temazepam*		

SMOKING CESSATION

$$$	Zyban
$$$$$	Habitrol

STROKE PREVENTION

$$$$	Ticlid

Note: Aspirin and warfarin are also used to prevent stroke.

ULCER

Treatment		$$$$$	Prevacid
$$$	cimetidine*	$$$$$	Prilosec
$$$$	Carafate	**Prevention**	
$$$$	Zantac*	$$$$	Cytotec

MISCELLANEOUS

$	Dilantin	$$$	Zovirax
$	Klotrix, K-Dur Slow-K*, K-Lyte	$$$$	Asacol
		$$$$	Combivent
$	Levoxyl	$$$$	Creon
$	Norpace*	$$$$	Epivir
$	Prenate Ultra, Zenate	$$$$	Lamictal
$	Proctocort, Cortenema	$$$$	MZM*
$	Pronestyl*	$$$$	Prolixin Decanoate
$	Provera*	$$$$	Rowasa
$$	Miacalcin Nasal Spray	$$$$	Serophene
$$	Midrin	$$$$	Stadol NS
$$	Natalins Rx	$$$$$	Cortifoam
$$	Nor QD	$$$$$	DDAVP
$$	Prolixin*	$$$$$	Depakene
$$	Quinidex Extentabs*	$$$$$	DHE
$$	Skelaxin	$$$$$	Helidac
$$	Tenex	$$$$$	Profasi HP
$$	Valtrex	$$$$$	Retrovir
$$$	Atrovent	$$$$$$	Aricept
$$$	Cerumenex	$$$$$$	Avonex
$$$	Cleocin Vaginal Cream	$$$$$$	CoLyte
$$$	Depakote	$$$$$$	Imitrex
$$$	Didronel	$$$$$$	Invirase
$$$	Ergostat	$$$$$$	Metrodin, Fertinex
$$$	Florinef	$$$$$$	Mucomyst
$$$	Klonopin	$$$$$$	Parlodel
$$$	Neurontin	$$$$$$	Pergonal
$$$	Norpace CR*	$$$$$$	Rocaltrol
$$$	Proctocream-HC	$$$$$$	Synarel
$$$	Proctofoam-HC	$$$$$$	Testoderm
$$$	Pronestyl SR	$$$$$$	Tritec
$$$	Tegretol, Tegretol XR		

COVERED INJECTABLES

- Ana Kit / Epipen
- Avonex
- Betaseron
- Caverject
- Glucagon
- Imitrex
- Insulin

Note: Other injectables may be covered under your medical plan. Betaseron, Avonex and Imitrex require Prior Authorization.

Kansas State Employees Prescription Drug Program

Member Formulary

The following are answers to some questions you may have about the Kansas State Employees formulary:

What is a formulary?

A formulary is a list of safe and cost effective drugs, chosen by a committee of physicians and pharmacists. Formularies have been used in hospitals for many years to help ensure quality drug use. The Kansas State Employees formulary will be continually revised to reflect the changing drug market.

Should I ask my physician to switch my current medications to formulary medications?

Many of your medications will already be on the formulary. However, if you have one that is not, ask your physician to choose a similar formulary product for you to use.

Should I use generics?

There are many medications on the market that do not come in generic form. For those drugs that do, your pharmacist should suggest safe and effective generic alternatives.

Advance Paradigm, Inc. ©1997 – Kansas State Employees Formulary

Analysis of HB 2360

HB 2360 - Mandates coverage for "diagnosis and treatment of osteoporosis". The purpose of the act is to provide insurance coverage to individuals with a condition or medical history for which bone mass measurement (bone density testing) is determined to be medically necessary for the individual's diagnosis and treatment of osteoporosis.

Pursuant to K.S.A. 40-2248, prior to legislative consideration of any bill that mandates health insurance coverage for specific health services, specific diseases, or for certain providers of health care services as part of individual, group or blanket health insurance policies, the person or organization which seeks sponsorship of such proposal shall submit to the legislative committees an impact report that assess both the social and financial effects of the proposed mandate coverage.

Pursuant to K.S.A. 40-2249, survey questions were designed to assist in assessing the impact of a proposed mandate of health coverage. The companies surveyed are top health care premium writers in Kansas, which means the most individuals with health care coverage in Kansas are covered by these companies. Of 15 companies sent the survey, 12 companies responded to the survey.

1. Is coverage required by HB 2360 already provided by your company

Yes/No

Yes:
- Central Benefits National Life Ins. Co.
- American Family Mutual Insurance Company
- Preferred Plus of Kansas
- Principal Mutual Life Insurance
- Principal Health Care of Kansas City, Inc.
- Exclusive Healthcare Inc.
- United Wisconsin Life Insurance Company
- CIGNA HealthCare of Ohio

No: None

Other answer:
Kaiser Permanente - "....Health Plan is not an indemnity insurance company. .....Kaiser Permanente provides comprehensive care to its members, from doctor visits to hospitalization. KP provides this care under one roof: pharmacy, labs, ex-rays, and physicians. KP medical decisions are made by the physicians....KP believes it is vital that any proposed mandates such as HB 2360 would protect the right of physicians to make clinical treatment decisions in consultation with their patients, free from outside interference...."

Blue Cross Blue Shield of Kansas - "we reimburse claims for such services if the diagnosis of osteoporosis is made. If no such diagnosis is made, then we deny the claim. We do reconsider such denied claims and based on medical records, determine whether significant risk factors are present which are common precursors of osteoporosis. If such risk factors are present, then payment for the diagnostic tests are covered. If the required factors are not present, then the claims remain denied."

Humana Health Care Plans - "This type of testing if currently being provided for in conjunction with a diagnosis of osteoporosis or for confirmation of a diagnosis for such condition."

Blue Cross and Blue Shield of Kansas City - "This coverage is provided as part of a follow-up or treatment of an already diagnosed care of osteoporosis. It is not covered as a diagnostic test."

2. If coverage required by HB 2360 is currently provided by your company, please provide us, for the last twelve months, with the average number of claims paid per month and the dollar amount paid per claim.

Company	Average/mo	Average benefit/claim
Central Benefits National Life Ins. Co.	5.83	$ 175.74
American Family Mutual Insurance Company	Unknown	Unknown
Kaiser Foundation Health Plan of Kansas City	Not claims based	Not claims based
Preferred Plus of Kansas	.5 (6 claims in 12 mo)	$ 225.00
Blue Cross Blue Shield of Kansas	2000 (under age 65)	$100.00
Principal Mutual Life Insurance	1	$45.67
Principal Health Care of Kansas City, Inc.	4	$283.39
Exclusive Healthcare Inc.	1	$44.20
United Wisconsin Life Insurance Company	5	$111.00
Humana Health Care Plans	38	$1668.18
CIGNA HealthCare of Ohio	1.3	$253.00
Blue Cross Blue Shield of Kansas City	Not available	$143.50

3. If coverage required by HB 2360 is not provided by your company, please provide us, for the last twelve months, the average number of claim denials per month for payment of such service.

Company	Number of claims denied/mo.
Central Benefits National Life Ins. Co.	NA
American Family Mutual Insurance Company	NA
Kaiser Foundation Health Plan of Kansas City	Not a claims based organization
Preferred Plus of Kansas	NA
Blue Cross Blue Shield of Kansas	75 claims per month
Principal Mutual Life Insurance	NA
Principal Health Care of Kansas City, Inc.	0
Exclusive Healthcare Inc.	NA
United Wisconsin Life Insurance Company	Blank
Humana Health Care Plans	NA
CIGNA HealthCare of Ohio	NA
Blue Cross Blue Shield of Kansas City	Not available

4. Will HB 2360 increase the cost of scientifically proven bone mass measurement?

Company	Yes	No
Central Benefits National Life Ins. Co.		No
American Family Mutual Insurance Company	If treatment protocols change, Yes, if no, NO	
Kaiser Foundation Health Plan of Kansas City	No response	
Preferred Plus of Kansas		No
Blue Cross Blue Shield of Kansas	No response	
Principal Mutual Life Insurance	Unknown	
Principal Health Care of Kansas City, Inc.		No
Exclusive Healthcare Inc.		No
United Wisconsin Life Insurance Company		No
Humana Health Care Plans	Difficult to determine	
CIGNA HealthCare of Ohio		N
Blue Cross Blue Shield of Kansas City	Yes - increase in frequency if required to be covered for diagnostic purposes. Should be minimal	

5. Please describe to extent to which (if any) HB 2360 might increase the use of bone density testing.

Company	Comments:
Central Benefits National Life Ins. Co.	None
American Family Mutual Insurance Company	Again, If treatment protocols change or if it includes new technologies, the use could increase, if not, then little impact
Kaiser Foundation Health Plan of Kansas City	
Preferred Plus of Kansas	If coverage for this procedure is mandated by legislation, the use of the test will likely increase because providers and individuals will have open access, if no medical necessity needs to be documented.
Blue Cross Blue Shield of Kansas	We believe it is reasonable and probable that given the availability of coverage for such services, the utilization will clearly increase. For the purpose of this response, we have assumed that every woman currently getting a (routine) screening mammogram, presumably as a result of her annual check, would also now get a bone density test. Calculations: .6% increase in total claims payments and corresponding premiums.
Principal Mutual Life Insurance	Allow for this testing already and do not expect to see an increase in the use of this test.
Principal Health Care of Kansas City, Inc.	No response.
Exclusive Healthcare Inc.	No response.
United Wisconsin Life Insurance Company	Do not think it will increase use of the testing.
Humana Health Care Plans	Would expect Humana physicians to use the best tests available to provide treatment for our Kansas members, thus it would be difficult to determine what increase, if any HB 2360 would have on the use of bone density testing.
CIGNA HealthCare of Ohio	No increase expected.
Blue Cross Blue Shield of Kansas City	Expect that the use of bone density testing will multiply by a factor of 2 to 3 times for diagnostic cases.

6. Please describe the extent to which (if any) insurance premiums can be reasonable expected to increase or decrease as a result of passage of HB 2360 for each of the following categories as a percentage of premium.

Company		Ind.	Ind./Sp	Ind./child	Ind./Sp/Ch
Central Benefits National Life Ins. Co.		NA	NA all already covered	NA	NA
American Family Mutual Insurance Company		Unknown	--	--	--
Kaiser Foundation Health Plan of Kansas City		No answer	--	--	--
Preferred Plus of Kansas	NA	NA all already covered	NA	NA	
Blue Cross Blue Shield of Kansas		We provide a general impact and it is extremely labor intensive to split the general impact up by membership type. However, if the calculations were made, the differentiation between the types of membership in terms of premium impact of this mandate would be minimal.			

Principal Mutual Life Insurance	NA	NA	NA	NA
Principal Health Care of Kansas City, Inc.	None	None	None	None
Exclusive Healthcare Inc.	No Increase anticipated -- --			
United Wisconsin Life Insurance Company	None	None	None	None
Humana Health Care Plans	Overall rate impact on premiums would be minimal if the bone density testing is provided only for individuals who are at risk and it is determined to be medically necessary for the individual's diagnosis and treatment of osteoporosis.			
CIGNA HealthCare of Ohio	None	None	None	None
Blue Cross Blue Shield of Kansas City	The impact on premiums should be negligible.			

7. Please estimate the impact, if any, of HB 2360 on the total cost of benefit payments, for accident and sickness insurance (as a percentage of total claims payments).

Company	Percentage
Central Benefits National Life Ins. Co.	NA - already covered
American Family Mutual Insurance Company	Unknown
Kaiser Foundation Health Plan of Kansas City	No response
Preferred Plus of Kansas	None - already covered
Blue Cross Blue Shield of Kansas	Minimal impact
Principal Mutual Life Insurance	None - already covered
Principal Health Care of Kansas City, Inc.	None
Exclusive Healthcare Inc.	No impact
United Wisconsin Life Insurance Company	None
Humana Health Care Plans	Difficult to determine impact on total cost of benefit payments for accident/sickness insurance under the provisions of HB 2360.
CIGNA HealthCare of Ohio	None
Blue Cross Blue Shield of Kansas City	None

POLSINELLI
WHITE
VARDEMAN &
SHALTON

Memorandum

TO: The Honorable Bob Tomlinson, Chairman
House Insurance Committee

FROM: William W. Sneed, Legislative Counsel
Health Insurance Association of America

RE: H.B. 2770

DATE: February 8, 2000

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent the Health Insurance Association of America ("HIAA"). HIAA is the nation's leading advocate for the private, market-based health care system. Our 255 plus members provide health insurance to approximately 110,000,000 Americans. We appreciate this opportunity to provide comments on H.B. 2770. After reviewing the bill, we appear today in opposition to its passage.

Much of this testimony will provide my client's position relative to mandates in general as it relates to health insurance in the commercial insurance arena. However, before providing that information, we would like to comment on specific provisions of H.B. 2770.

My client is unaware of any insurance contract that would not cover bone mass measurement (bone density) testing and/or the diagnosis and treatment of osteoporosis. As noted on lines 18-19, such treatment would be "medically necessary." To the best of our knowledge, all insurance contracts under the purview of the Kansas Insurance Department require coverage for "medically necessary" testing and/or treatment.

HSE Ins Comm
2-8-00
At 9

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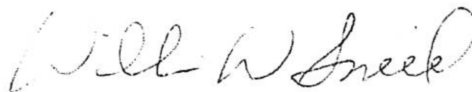
What we believe may be the intent of the authors of the bill is a requirement for a bone mass measurement (bone density testing) regardless of a physician's determination of medical necessity. If this assumption is correct, then the authors of the bill are attempting to create a mandate similar to those service mandates that are currently found in Kansas statutes. If so, we have not been provided any documentation that would verify such a mandate would be cost effective as it relates to the current marketplace.

As stated earlier, my client opposes mandated benefit laws for a variety of reasons. Attached to my testimony is a study prepared by Dr. Gail A. Jensen and Dr. Michael A. Morrisey regarding mandated benefit laws and employer-sponsored health insurance. We believe the attached documentation demonstrates that notwithstanding the fact that some mandated benefit has a good "sound bite," in reality such mandates are cost drivers and can have the opposite affect in the marketplace.

Based upon the foregoing, my client urges the Committee to reject H.B. 2770. Thank you very much for the opportunity to provide testimony, and if you have any questions, please feel free to contact me.

Respectfully submitted,



William W. Sneed

Attachments: 1

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HIAA

Health Insurance Association of America

Mandated Benefit Laws and Employer-Sponsored Health Insurance

Gail A. Jensen, Ph.D.
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PREFACE

In 1989, the Health Insurance Association of America (HIAA) published a study entitled *The Price of State Mandated Benefits*, co-authored by Jon Gabel and Gail A. Jensen. At that time, states had passed more than 700 mandates, most of which required insurers to cover specific diseases or to pay for the services of certain types of providers. The study concluded that mandates raised the price of insurance coverage, discouraged small businesses from providing coverage, and encouraged firms to self-insure. A decade later, HIAA decided to reexamine these issues, although changes in patterns of insurance regulation meant that we would now be examining the effect of federal as well as state mandates.

HIAA again commissioned Gail A. Jensen, Ph.D., of the Department of Economics and Institute of Gerontology, Wayne State University, and Michael A. Morrisey, Ph.D., of the Lister Hill Center for Health Policy, University of Alabama-Birmingham (who had contributed econometric work to the prior study), and asked them to examine the cost and consequences of benefit mandates.

The following are highlights of their study:

- One in five to one in four uninsured Americans lacks coverage because of benefit mandates.
- The number of state mandates increased at least 25-fold between 1970 and 1996.
- Workers pay for mandated benefits in the form of reduced wages or fewer benefits, as well as higher insurance premiums.
- As the number of benefit mandates increases, the cost of coverage rises, and as costs rise, more and more firms seek to self-insure to avoid the added expenses imposed by mandates.
- Given that ERISA preempts self-insured firms from state mandates, the passage of such mandates will not lead to substantially more people with a given benefit. Indeed, a state mandate that applies to private group plans will cover, on average, only 33 percent of a state's population, whereas one that applies to all private group plans and individually purchased policies will cover about 42 percent of a state's population.
- Smaller firms are disproportionately affected by mandates in part because they are less likely than larger firms to be able to avoid the costs of mandates by self-insuring. This, in turn, implies that, because health insurance will be more expensive for smaller firms (because they must include the new benefit), they will be less likely to offer coverage to employees.
- Mandates cost money. In Virginia, mandates accounted for 21 percent of health insurance claims; in Maryland, they accounted for 11 to 22 percent of claims; and in Massachusetts, 13 percent of claims.

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- Several benefits are particularly expensive. Chemical dependency treatment coverage increases a plan's premium by 9 percent on average; coverage for a psychiatric hospital stay increases it by 13 percent; coverage for visits to a psychologist increases it by 12 percent; and coverage for routine dental services raised premiums by 15 percent.

The proliferation of mandated benefits has increased the cost of health insurance, disproportionately hurting employees who work for small businesses. But benefit mandates enjoy tremendous political popularity, and serve frequently as central items on the campaign platforms of candidates running for political office. While individually, such benefit mandates may be hotly supported by certain interest groups, the cumulative effect has had a measurably detrimental impact on the ability of Americans to afford health insurance coverage. Policy makers, then, need to be aware that what is politically expedient may come with a high price tag as well as clearly foreseeable harmful consequences for health care consumers.

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Introduction

Currently, well over 1,000 coverage mandates are in place across the country; and state and federal lawmakers give every indication of increasing their involvement in group insurance markets. State legislatures and Congress have passed a wide variety of mandates. Some require that particular types of providers or particular services be covered. Others deal with the guaranteed issue and renewal of policies, waiting periods, and the treatment of pre-existing conditions. More recently, some specify a minimum number of covered hospital days following certain medical procedures, or deal with the nature of the provider networks that managed care firms can establish.

While proponents of these laws believe that they enhance insurance coverage and improve the quality of care, mandates have been shown to increase premiums, and to cause declines in wages (and other fringe benefits); worse yet, mandates lead some workers and employers to forgo insurance coverage altogether. Furthermore, the cost of mandates falls disproportionately on workers in smaller firms, those least able to bear this burden.

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Current Scope of Group Insurance Regulation

Both the states and the federal government have enacted requirements for the content of health plans. But there are far more state laws than federal. These state laws include "conventional" mandatory-inclusion and mandatory-option laws that specify particular providers, services, and/or subscriber cohorts, as well as mandates relating to: (1) small-group reform laws, (2) specifics of coverage laws, and (3) provider network laws. (See Table 1.)

Most Common State Mandates in 1996

Required Coverage	Number of States with Mandates	Number Requiring Mandatory Inclusion	Number Requiring Mandatory Option
Provider Mandates			
Chiropractors	41	39	2
Psychologists	41	40	1
Optometrists	37	35	2
Dentists	34	35	1
Benefit Mandates			
Mammography Screening	46	42	3
Alcoholism Treatment	43	27	16
Maternity Length-of-Stay	34	34	0
Mental Health Care	32	18	14
Extension Mandates			
Conversion to Non-Group Policy	39	38	1
Continuation Coverage for Employees	38	37	1
Continuation Coverage for Dependents	35	34	1
Handicapped Dependents	34	34	0

TABLE 1

Source: Blue Cross Blue Shield Association (1997).
Note: Only laws applying to all insurers were counted.

Federal statutes affect the applicability of state insurance laws. The Employee Retirement Income Security Act (ERISA) effectively exempts self-insured firms from state insurance regulations. Nearly half (46 percent) of all covered workers are now in self-insured plans [Jensen et al. 1997] that are not subject to state insurance laws. Moreover, the federal HMO Act of 1973 and its amendments of 1988 appear to exempt federally qualified HMOs from some state mandated benefits, although, as Butler [1996] notes, the exemption provision of the HMO Act has yet to be tested in the courts. Many HMOs are federally qualified, and the majority of HMO subscribers are in federally qualified plans.

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State Mandates

State governments have been regulating the terms of private health plan coverage by means of mandates for over three decades. These laws initially consisted of mandatory-inclusion provisions: If insurance policies were sold in the state, they had to include coverage for the mandated provider type, service, or subscriber cohort, such as adopted children. Over time, the types of services and providers covered under state mandates for private health plans have grown.

Until the 1970s, nearly all state mandates were mandatory-inclusion laws. Mandatory-option laws began to appear in the early 1970s. The latter require that the insurer offer coverage for particular types of providers or services. Employers, however, have the option of not purchasing this additional coverage.

The trend in conventional mandates enacted across all the states since 1970 is illustrated in Figure 1. The number of state mandates increased at least 25-fold between 1970 and 1996. In 41 benefit areas alone, the number of mandates rose from 35 in 1970 to 860 in 1996.

States vary considerably in their philosophies towards mandates, as indicated by Figure 2. Some states, such as Delaware, Idaho, and Wyoming, have enacted relatively few conventional mandates, while others, such as California, Connecticut, Florida, and New York, have passed more than 25. By and large, states with the most mandates were the ones that got an early start enacting them.

In the late 1980s and early 1990s, states began to legislate newer forms of insurance mandates, attempting to improve the small-group market by specifying particular service obligations within coverages, and delineating the nature of managed care networks.

The extent to which small-group reform statutes were enacted is summarized in Table 2. These mandates typically focused on guaranteed issue and guaranteed renewal, portability of coverage, pre-existing condition clauses, and premium rating restrictions. By 1995, 45 states had enacted one or another of these sets of laws; 36 had enacted them all [Hing and Jensen 1998].

Mandates in the 1990s have included provisions dealing with the coverages offered by managed care plans. Some 19 states currently establish a standard definition of the need for emergency room care. Hospital length-of-stay mandates, which now exist in 35 states, establish minimums for hospital care coverage following certain medical procedures. Gag rules prohibit clauses in the provider contracts of managed care plans that might restrict communication between patients and their physicians; a majority of states (39) now have them [EBRI 1998].

Most states have also enacted one or more laws to regulate the nature of the provider panels created by managed care firms. The best known of these are the any willing provider (AWP) and freedom of choice (FOC) laws, but they also include direct-access laws that allow subscribers to use specific types of in-network specialists without first obtaining a referral from the primary care physician.

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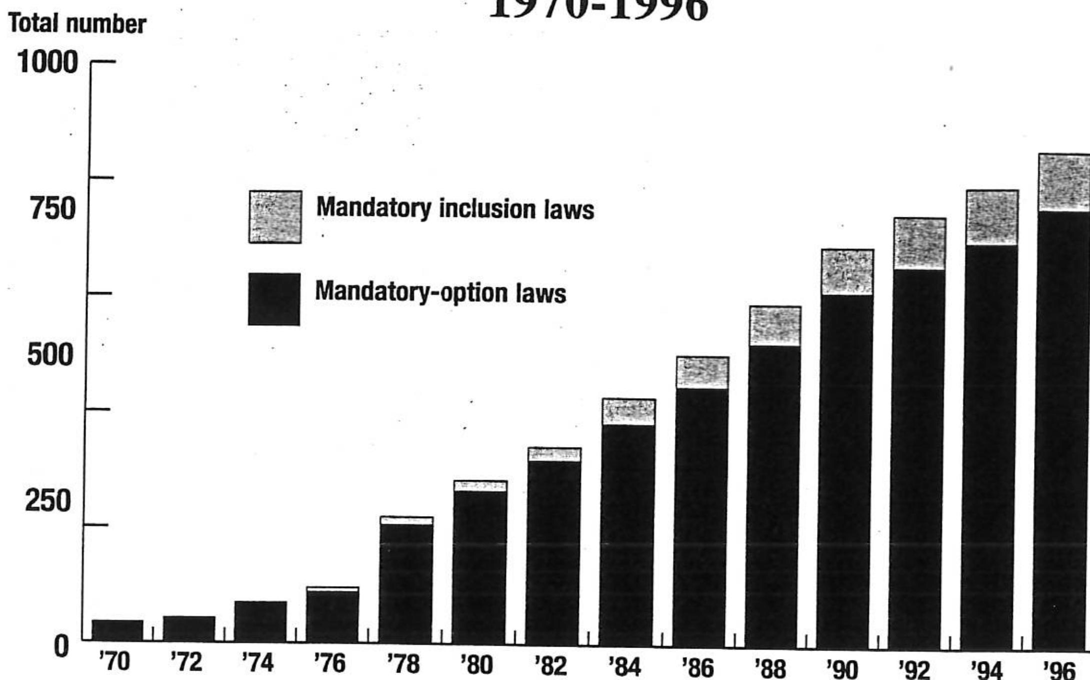
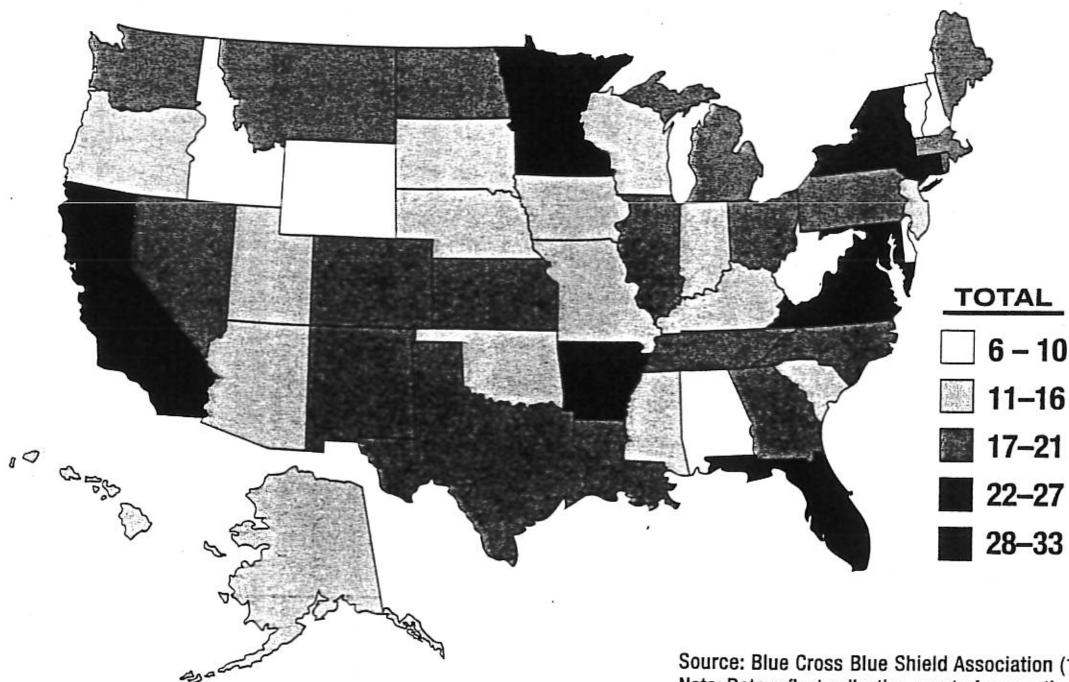
Growth in States' Conventional Mandates, 1970-1996



Source: Blue Cross Blue Shield Association (1997)
Note: Data reflect collective count of conventional mandates across all states, which pertain to 41 aspects of plan coverage.

FIGURE 1

Conventional Mandated Benefits by State, 1996



Source: Blue Cross Blue Shield Association (1997)
Note: Data reflect collective count of conventional mandates across all states, which pertain to 41 aspects of plan coverage.

FIGURE 2

9-100

State Small Group Insurance Reforms

Type of Measure	Number of States Which Had Enacted the Measure as of: 1989	1991	1993	1995
Mandate-Waiver Plans Can be Sold	1	9	31	43
Guaranteed Issue Requirements	0	5	30	38
Guaranteed Renewal Requirements	1	18	40	43
Portability of Coverage Requirements	3	16	40	43
Limits on Waiting Periods for Coverage of Pre-existing Conditions	11	25	43	45
Premium Rating Restrictions	1	20	42	45

Source: Jensen and Morrisey (1999).

TABLE 2

States with Alternative AWP and FOC Laws

	Provider Covered: Physician	Hospital	Pharmacy
Any Willing Provider Laws:			
HMO			
1989	5	3	7
1995	11	9	25
PPO			
1989	7	3	7
1995	11	7	22
Freedom of Choice Laws:			
HMO			
1989	3	4	4
1995	5	5	16
PPO			
1989	4	4	6
1995	6	5	18

Source: Calculated from Ohsfeldt et al. (1998).

TABLE 3

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The growth and extent of AWP and FOC laws is summarized in Table 3. AWP laws require managed care plans to allow any provider to be included in the network if he or she is willing to abide by the terms and conditions of the network contract. FOC laws require that a managed care subscriber be allowed to step outside the network and obtain services from any licensed provider as long as the subscriber pays a larger amount out-of-pocket. The laws are complex in their application. Some apply only to HMOs, others only to PPOs, but often they apply to both. Laws covering pharmacies were the most common, although AWP laws applicable to physicians existed in 11 states.

Direct access mandates are FOC laws with a twist. They allow subscribers to bypass their physician gatekeepers to see certain types of specialists, but those specialists must be network providers. More than half the states (29) now mandate direct access to obstetricians-gynecologists, and a few mandate direct access to network dermatologists, ophthalmologists, psychiatrists, or chiropractors [EBRI 1998].

Federal Mandates

Whether purchased or self-insured, all plans are subject to several federal mandates, including the 1978 Pregnancy Discrimination Act, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the 1996 Health Insurance Portability and Accountability Act (HIPAA), the 1996 Mental Health Parity Act, the 1996 Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act of 1998.

With the exception of the recent mental health benefit mandates, the existing federal laws are of the mandatory-inclusion variety. The mental health parity requirements, however, are similar to the newer state mandates that specify specific conditions of service (if the benefit is provided). Moreover, most of the federal mandates were preceded by a large number of state mandates in these same areas of coverage. In most cases, the federal laws represent new mandates for only a minority of states.

The federal mandates are significant in two respects, however. First, they directly amend ERISA to apply to self-insured plans as well as purchased products. Second, they may be a harbinger of the "federalization" of health insurance regulation.

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Why Choose to Mandate?

Why have the states and the federal government passed so many laws regulating health insurance? One view of benefit mandates is that they spring from a widespread desire to correct inefficient or inequitable market practices. This so-called "public interest" view holds that health insurance mandates are designed to correct problems in the health care market. Mandates are viewed as an attempt to provide access to coverage or specific treatment practices valued by subscribers but withheld by employers or insurers.

The alternative view of legislation is that the laws and regulations stem from an attempt by self-interested parties to further their private interests. This "public choice" view holds that the passage of insurance mandates is driven by providers of clinical services who want to increase the demand for their services or thwart the ability of their rivals to achieve a competitive advantage. Passage of mandates may also be driven by patient advocacy groups (e.g., those representing persons needing certain services) who want to lower the out-of-pocket costs for certain services. By requiring coverage of the service, its net price is reduced, and so more people utilize the service. In general, proponents of mandates are special interest groups that stand to personally benefit from the laws

As for legislators, they trade their support for mandates for political support—votes, publicity, campaign contributions—from core constituencies that have a stake in the enactment of a mandate. Thus, legislative benefits accrue to relatively small groups of people who are deeply committed to a particular issue. Costs, on the other hand, are spread across a broad majority. Thus, proposed legislation would generally have a very large, direct financial impact on providers or suppliers of goods or services, while the impact on purchasers would be diffused over a much larger group of individuals.

Providers also find it easier to organize than would consumers in general. As a result, the primary proponents and opponents of legislation tend to be providers or suppliers, whose gains or losses are large enough to warrant the costs of political action. In the health care field, provider groups have been the primary proponents of legislation.

The direct evidence with respect to the enactment of insurance mandates is thin but is generally consistent with the view that the laws reflect provider efforts. There is a much wider literature on health legislation that reaches the same general conclusion.

The Economics of Mandates and Employer-Sponsored Health Insurance

Most people who purchase health insurance in the United States do so through their employer. Workers value health insurance, and it is less expensive when purchased through an employer than when purchased individually. There are three reasons for this. First, federal and state tax codes do not treat health insurance as taxable income. Second, employed individuals are generally healthier than those who are not, and are therefore likely to file fewer claims and have lower costs. Finally, administrative costs on a per-individual basis are lower when coverage is purchased through an employer.

People generally are paid what they are worth. Strictly speaking, they are paid the value of the output they produce. Workers can be paid in a variety of ways: wages; wages and a pension; wages, health insurance, and parking; and so on. However, the total cost of the compensation package can't exceed the value of the worker to the firm. If health insurance is to be part of the compensation package, some other element of the package must be reduced.

Employers will offer health insurance only if workers value it. Workers must give up wages or other benefits in return for the health insurance coverage. If they don't value the coverage, they might be better off working for a firm that offers only wages (or other benefits that workers value more).

Economics suggests that employers will offer health insurance plans that are valued by their workers, with coverages that reflect the preferences of the employees. If not, employers will have to compensate by raising wages or other benefit levels, or the workers may become dissatisfied and decide to work elsewhere.

Given all this, the economics of insurance mandates are straightforward. Suppose a new coverage, say for eyeglasses, is mandated in all plans. Obviously, if a firm already offers the coverage, then the mandate has no effect on that employer. Labor and insurance market effects occur only when the mandate requires coverage that employers don't offer voluntarily because workers don't place a high value on it.

The new coverage will raise the cost of insurance. The labor market will adjust to reflect the additional cost. Wages may be reduced to pay for the new benefit, or other, non-mandated benefits may be eliminated. In a smoothly functioning labor market, workers necessarily bear the cost in one form or another. They now have to pay for an eyeglasses benefit that they previously didn't value enough to pay for. This is the first consequence of a mandate: Wages, other health benefits, or non-health benefits will be reduced to pay for the new coverage.

Proponents of mandated benefits argue that the new coverage benefits workers. But this "benefit" comes with higher premiums. The burden of the mandate to workers, then, is the cost of the coverage over and above what they were willing to pay for it in the absence of a mandate.

It may be that workers will find the new insurance/wage package unattractive. This will lead them to look for an employer that does not offer the new coverage, or to find an employer that does not offer health insurance at all.

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This leads to the second consequence of mandates: Employees will have an incentive to seek out firms that do not offer coverage, or to drop coverage entirely, if the cost to them of the mandate is sufficiently high.

The employer has another option to try to mitigate the effect of the mandate. ERISA exempts self-insured plans from the reach of state insurance laws. This is the third consequence of mandates: Firms will seek to become self-insured to avoid the costs of the mandated coverage faced by their workers.

The ability to self-insure under ERISA has other implications for labor and insurance markets. This leads to the fourth consequence of mandates: In the presence of ERISA, a state mandate will not necessarily lead to substantially more people with the covered benefit. Many will be excluded by virtue of coverage through self-insured plans, and others will move to self-insured firms. (More federal mandates would effectively deny such firms some of the advantages of self-insuring.)

Self-insurance is not equally costly for all employers. When a firm self-insures, it becomes its own risk pool. Insurance risk declines as the size of the insurance pool grows. Therefore, smaller employers will face more risk in self-insuring than will larger firms. Thus, the fifth consequence of mandates is: Small employers will be disproportionately affected by virtue of being less able to avoid the mandate by self-insuring. This, in turn, implies that health insurance will be more expensive for small firms (because they must include the new benefit), and they will be more likely not to offer insurance. They will also tend to attract workers who value insurance coverage the least. Obviously, federal mandates are likely to have greater implications for the wage-benefit trade-off than state mandates because the federal mandates apply to self-insured plans as well.

These employer-labor market effects apply to all mandatory-inclusion laws. Mandatory-option laws have decidedly fewer effects because the firm is free to include or exclude the coverages as it chooses.

Laws that apply to only one type of insurer have additional effects because they change the attractiveness of one type of plan relative to another. AWP or FOC laws or gag rules that apply only to PPOs, for example, will raise premiums for PPOs relative to conventional plans, HMOs, and point-of-service plans. This is the final consequence of the economics of mandates: Laws that restrict only particular types of plans will reduce the attractiveness of those plans.

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Evidence of the Effects of Mandates

Who Is Affected by Mandates?

Most federal mandates cover all group health plans, whether self-insured or purchased, but some exclude certain plans from compliance. Sixty-one percent of Americans are covered by private group health insurance, and the majority of these people are entitled to most federally mandated benefits. (Medicare, Medicaid, and other government plans, as well as individually purchased policies, are excluded from compliance with most federal mandates. Some federal mandates, such as COBRA and the Mental Health Parity Act, also exclude small employers.)

In contrast, under a state mandate, a large majority of a state's population is unaffected because the laws apply only to purchased conventional, PPO, and POS plans, and HMOs. A state mandate does not cover persons who lack employer coverage to begin with; who are covered only by Medicare, Medicaid, or another government program; or who are covered by a self-insured group plan. A state mandate that applies to private group plans will cover, on average, only 33 percent of a state's population, whereas one that applies to all private group plans and individually purchased policies will cover about 42 percent of a state's population.

The numbers are low for several reasons. First, 30 percent of the population has Medicare, Medicaid, some other public coverage, or no coverage at all. These people are not subject to state mandates. Second, even among persons who have private coverage (70 percent), most of this coverage is beyond the reach of state laws. Nine percent have individual coverage. While state laws specify the nature of these individual insurance policies, they are typically not affected by group mandates.

Further, among all persons with private group coverage in 1995 (61 percent), 63 percent of conventional plan enrollees, 60 percent of PPO plan enrollees, 53 percent of POS plan enrollees, and 10 percent of HMO enrollees were in self-insured plans.

Of the 33 to 42 percent of persons in plans subject to state mandates, only those who were not already receiving the benefit gain access to it as a result of a new mandate law. These people are typically workers and their families participating in plans offered by smaller firms. This is because most small-firm coverage is insured (and thus subject to state mandates), and because insurance benefits offered by small firms tend not to be as rich as those offered by large firms [Jensen et al. 1997].

Of course, any failure to enforce state mandates would reduce their effectiveness even further. Thus, while one might assume that state mandates affect the preponderance of a state's population, in reality the opposite is closer to the truth. Less than half of a state's population is in plans affected by state mandates.

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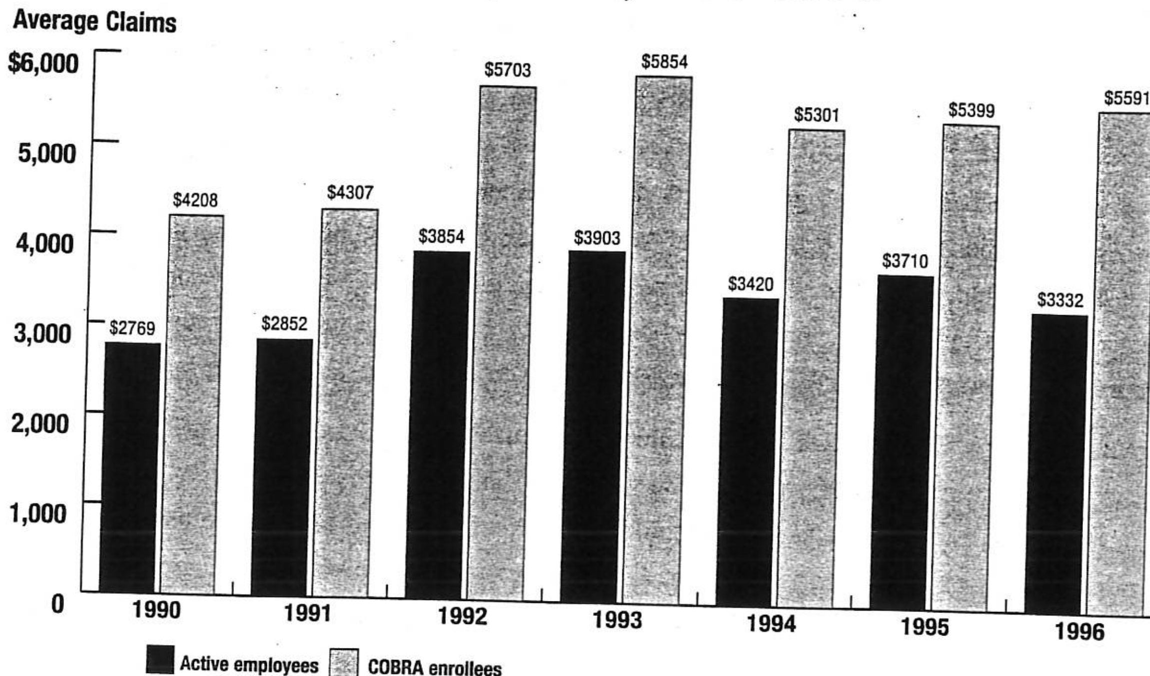

FIGURE 3

Source: Stephen A. Huth, COBRA Costs Continue to Be High, Erratic, *Employee Benefit Plan Review*, September 1997, 36–44.

What Do Mandates Cost?

The full costs of mandated benefits include not only the additional premiums, but also the consequent changes in access to health insurance, the nature of coverage, workers' compensation, and possibly even a firm's hiring practices.

In this section, however, our focus is on the more narrow notion of costs, namely, the extra premiums due to mandated coverages. These are important in their own right because it is the consequent changes in the cost of insurance that give rise to costs in other arenas. If premium increases are negligible, we can expect few other costs, whereas if they are large, other costs, too, are likely to be substantial.

In the case of state mandates, data on insurance claims in a state can be used to calculate the share of insurance claims associated with mandates. Using this method, mandated benefits in Virginia were found to account for 21 percent of claims; in Maryland, 11 to 22 percent of claims; in Massachusetts, 13 percent of claims; in Idaho, 5 percent of claims; and in Iowa, 5 percent of claims.

These estimates, however, are not a measure of the premium cost of mandates. The full share of claims cannot be attributed to mandates because some of the coverages likely would have been provided anyway. The more appro-

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priate measure is the "marginal cost" of mandates, which is the difference between actual costs and the costs that would have resulted without the mandates. Using a nationwide cross-section of insured firms in 1989, Acs et al. [1992] found that mandates significantly raised premiums. Among firms that offered health insurance, premiums were found to be 4 to 13 percent higher as a direct result of state mandated benefits.

Jensen and Morrisey [1990] provided information on the marginal cost of including specific types of coverage based on the actual experience of plans, which is also useful in gauging the cost of mandates. Several benefits, which many states have mandated, were found to be expensive. Chemical dependency treatment coverage increased a plan's premium by 9 percent on average. Coverage for a psychiatric hospital stay increased it by 13 percent. Adding benefits for psychologists' visits increased it by 12 percent, and adding benefits for routine dental services increased it by 15 percent. These estimates may slightly overstate the cost to an employer of complying with a new mandate in one of these areas because the sample of firms used in the study offered very generous benefits all around, and may have offered better coverage than a state would typically prescribe. The estimates nonetheless suggest that mandates can be expensive for firms that otherwise would not offer these coverages.

A survey conducted each spring by Charles D. Spencer & Associates, Inc., covering 1.4 million workers in approximately 200 firms, has consistently found that persons who elect COBRA coverage cost much more to insure than active workers. Average claims per COBRA enrollee in 1996, for example, were 68 percent higher than average claims per active worker ($5,591 vs. $3,332) [Huth 1997]. This is not a one-time finding, but rather one that has held up for years. (See Figure 3.) Workers, through their employers, are clearly paying a huge subsidy for each continuation enrollee, and such adverse selection is bound to raise group premiums. Since COBRA enrollees on average comprise 2.2 percent of all plan enrollees [Huth 1997], premiums per normal enrollee are 4 percent higher than they would be were it not for the COBRA mandate.

COBRA also imposes administrative costs on a firm, including the costs of communicating continuation rights to eligible individuals, collecting premiums from these enrollees, and, in some cases, monitoring their right to continued eligibility. Although probably small in relation to incremental premiums, the administrative costs are still significant. Estimates for 1990, for example, were in the range of $150 to $240 annually per COBRA enrollee [Charles D. Spencer & Associates, Inc., 1990].

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Are Wages Reduced as a Result of Mandates?

A key result of the economics of employer-sponsored health insurance is that workers pay for the coverage in the form of reduced wages or fewer benefits.

Recent research on workers' compensation insurance suggests that wages are lower in the presence of other benefits. These studies are particularly important because, like health insurance mandates, workers' compensation coverage is mandated by state law. In these studies, researchers were able to carefully account for the size of the benefits received if a person were injured, and they used particularly good measures of the risk of injury. Gruber and Krueger [1991] found that over 86 percent of the costs associated with workers' compensation were borne by workers in the form of lower wages. Viscusi and Moore [1987] concluded that all the costs were borne by workers.

The only study examining the effects of health insurance mandates on workers' wages is that of Gruber [1994]. He examined the effects of state maternity mandates implemented in 1976-1977 in Illinois, New Jersey, and New York, prior to the federal mandate. His results indicated that the full cost of the mandates was paid by women ages 20 to 40. The difference in wages of married women ages 20 to 40, for example, was 4.3 percent lower in Illinois, New Jersey, and New York after the mandate than they were for similar women in the control states over the same period. This is dramatic evidence that workers pay for the cost of mandates in the form of lower wages.

Do Some Workers Lose Coverage as a Result of Mandates?

If mandates increase the cost of coverage, it is possible that some buyers, whether firms or individuals, will decide that health insurance simply isn't worth it, in which case the number of purchasers will decline.

Using data from 1989 to 1994, Sloan and Conover [1998] found that the higher the number of coverage requirements placed on plans, the higher the probability that an individual was uninsured, and the lower the probability of people having any private coverage, including group coverage. The probability that an adult was uninsured rose significantly with each mandate present. Because their analysis had exceptionally high statistical power—it included more than 100,000 observations—these findings are quite persuasive.

These results suggest that eliminating benefit mandates entirely would reduce the proportion of uninsured adults by approximately four percentage points, i.e., from 18 to 14 percent of the non-elderly population. This implies that one-fifth to one-quarter of the uninsured problem is due to the presence of state mandates. The study's findings confirm those of an earlier study by Goodman and Musgrave [1987], who estimated that, in 1986, 14 percent of the uninsured nationwide lacked coverage because of mandates.

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Have Mandates Encouraged Firms to Self-Insure?

Since ERISA exempts self-insured plans from state regulation, it is conceivable that state-mandated benefits have spurred some firms to self-insure as a way of avoiding coverage requirements. The importance of mandates in self-insurance decisions has been the subject of several studies. Jensen et al. [1995] estimated the impact of state mandatory-inclusion mandates on the decisions of mid- to large-sized firms (50 or more workers) to convert to self-insurance during the early and mid-1980s. Most mandated benefits had a positive but statistically insignificant effect on the likelihood of conversion. Even when considered collectively, mandates did not explain conversions to self-insurance that occurred between 1981 and 1984/85, nor those that occurred between 1984 and 1987.

Greater premium taxation of purchased plans, however, was found to strongly encourage self-insurance. Both premium taxes and state risk-pool taxes were found to have significant effects on the likelihood of converting. Between 1981 and 1984/85, the presence of a state continuation-of-coverage requirement also encouraged self-insurance but was not a factor for the later period examined. One interpretation is that when COBRA took effect in early 1986, self-insurance was no longer a way to avoid offering continuation rights. As noted earlier, continuation benefits have been found to raise premiums substantially (e.g., by 4 percent).

Do Mandates Disproportionately Affect Small Firms?

Mandates have increased the uninsured population, priced some small firms out of the group market altogether, and forced workers to go uninsured or buy coverage on their own. Jensen and Morrisey [forthcoming] document the effects of the laws on small firm coverage over the 1989–1995 period for firms with fewer than 50 workers. Each additional mandate significantly lowered their probability of offering health insurance. The findings suggest that eliminating all mandates would have raised the proportion of small firms that offered coverage by 9.4 percentage points, or from 49 percent to 58.3 percent. Small firms that would sponsor coverage, were it not for the presence of mandates, comprise 18 percent of all uninsured small businesses.

In an earlier study [1992], Jensen and Gabel examined the separate effects of different types of benefit mandates on small firms' decisions to offer coverage. Although most individual mandates had negligible effects, Jensen and Gabel found that, even in the mid-1980s, state mandates accounted for 19 percent of non-coverage among small firms. The most troublesome mandates were state continuation-of-coverage rules. These pre-COBRA state mandates allowed terminated workers to buy into the firm's plan. Continuation mandates have been found to give rise to acute adverse selection and, hence, to raise premiums. This finding suggests that, in small firms, which typically have high worker turnover, these effects may be especially severe.

However, Uccello [1996] and Jensen and Morrisey [forthcoming] found that small firms were no less likely to offer coverage in states with pre-existing condition mandates. One explanation is that problems with insurer restrictions on the coverage of pre-existing conditions were never widespread to begin with, so the laws, in effect, were "non-binding" limits. Indeed, for years the coverage of pre-existing conditions in the small-group market has been about the same as in the large-group market [Jensen and Morrisey 1998].

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CONCLUSIONS

Four conclusions emerge. First, both conventional mandates specifying coverage for particular provider types and services, and newer mandates affecting small-employer markets and managed care plans have expanded dramatically at the state level during the 1980s and 1990s. Federal laws regulating the nature of health coverage have also grown. While many of the federal measures have tended to mimic similar state laws already in place, the federal laws potentially have a larger impact because they affect the coverage of the approximately 43 percent of workers who are enrolled in self-insured plans. Moreover, it appears that health insurance legislation may be becoming federalized as Congress considers even more coverage mandates.

Second, most state mandates affect less than half of the state's population. Thus, state efforts to increase access to particular benefits can have only limited success. Moreover, the effect of the laws falls disproportionately on workers in small firms because these firms are less able to self-insure and avoid the consequences of the mandates.

Third, mandated benefit laws do have negative effects. This is particularly true of the conventional mandates that have required inclusion of specific benefit provisions. Recent work indicates that a fifth to a quarter of the uninsured have no coverage because of state mandates. Federal mandates are likely to have even larger effects.

Finally, and perhaps most important, workers pay for health insurance mandates in the form of reduced wages or fewer benefits. If insurance plans are required to expand benefits or remove cost-containment devices, premiums rise. Workers and their employers may be able to avoid some of these costs by switching to less desirable plans or by self-insuring. To the extent that they cannot, wages or other forms of compensation must fall.

Mandates are attractive. Their proponents argue that they guarantee access to particular coverages, expand benefits, and enhance quality. More than that, they are off-budget. The costs don't appear as explicit items in state or federal budgets. However, mandates are not free. They are paid for by workers and their dependents, who receive lower wages or lose coverage altogether.

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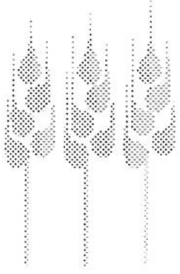

Kansas Association of Health Plans

Testimony before the
House Insurance Committee
The Honorable Robert Tomlinson, Chairman
<u>Hearings on HB 2770</u>
February 8, 2000

Chairman Tomlinson and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and others who support managed care. KAHP members serve many of the Kansans enrolled in an HMO.

The KAHP appears today in opposition to HB 2770. This bill mandates that a health insurer provide coverage for bone density testing.

Once again, of the HMO's responding to my survey, all currently provide coverage for bone density testing if the individual has a condition, medical history or is over menopause and the test is determined to be medically necessary. Again, this testing is a covered benefit not because the government has demanded that we allow it, but because this is what the marketplace has demanded of us.

In conclusion, the KAHP would request that you continue to allow us to meet the demands of the marketplace rather than enacting another mandate that could inadvertently cause the cost of health insurance to rise. If the goal is to devise a one-size fits all coverage, then we are getting closer and closer to accomplishing that goal. The ability to provide a choice in types and expense of health insurance plans is becoming less and less with each new mandate passed. Finally, if you feel this is a necessary mandate then we would strongly suggest that this legislation first be subject to the provisions of K.S.A. 1999 Supp. 40-2249a. This statute which you passed last year, requires the testing of any new mandate first on the state employees health plan in order to determine its cost impact.

I will be happy to try to answer any questions the committee may have.

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The University of Kansas Medical Center

DIVISION OF ENDOCRINOLOGY, METABOLISM AND GENETICS

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February 2, 2000

The Honorable Bob Tomlinson
State Representative
State Capitol, Room 112-S
Topeka, Ks. 66612

RE: HB 2770

Dear Chairman Tomlinson,

I am writing to express my opinion on House Bill 2770 regarding insurance coverage for measuring bone density to diagnose osteoporosis. I am Director of the Hiatt Osteoporosis Center at the University of Kansas Medical Center and have cared for patients with osteoporosis for over 30 years. I also serve on the Scientific Advisory Board of the National Osteoporosis Foundation.

There is no doubt that the use of bone densitometry has greatly improved the care of patients at risk for osteoporosis related fractures. Identification of patients at risk followed by therapeutic intervention has been shown to decrease the risk for fracture by 50% in postmenopausal women. Therefore, we should do everything possible to encourage the use of this diagnostic tool. We must also assure that the tool will be used effectively. I believe that the proposed bill should include more specific indications which I will discuss below.

Reimbursement should be assured for bone mass measurements for:

1. All postmenopausal women.
2. Premenopausal women with the following conditions:
   - Low estrogen states eg eating disorder, elite athletes, pituitary tumors, etc
   - Taking glucocorticoids or other medications affecting bone metabolism
   - History of atraumatic fractures
   - Immobilization or paraplegia
   - Disorders of calcium or bone metabolism such as hyperparathyroidism, vitamin D deficiency etc. or other disease states know to affect bone metabolism such as hyperthyroidism, malabsorption, malnutrition etc.

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4. Any man who has:
   - Suffered a fracture without significant trauma.
   - Taken or will be taking glucocorticoids or other medications know to affect bone.
   - Hypogonadism
   - Any disease known to affect bone metabolism
5. Any man or woman with x-ray findings suggestive of osteoporosis.

I hope that these recommendations will be helpful.

Sincerely,

Barbara P Lukert, MD

Barbara P. Lukert, MD, FACP
Professor of Medicine
Director of Hiatt Osteoporosis Center
University of Kansas School of Medicine and Hospital

CC: Thomas Covert, MD
Corporate Medical Director
Blue Cross Blue Shield of Kansas