Approved: March 2, 2000
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Rep. Robert Tomlinson at 3:30 p.m. on February 10, 2000 in Room 519-S of the Capitol.

All members were present except:

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

Conferees appearing before the committee: Kathleen Sebelius, Commissioner Kansas Insurance Dept.
Barbara Duke, American Association of University Women
Karla Wilmott, Quality Management Planned Parenthood
Carla Norcott-Mahany, Planned Parenthood
Bill Sneed, Health Insurance Association of America
Larry Ann Lower, Kansas Association of Health Plans
Judy Smith, Concerned Women for America of Kansas
Terry Leatherman, Kansas Chamber of Commerce & Industry
Cleta Renyer, Right to Life of Kansas
Beatrice Swoopes, Kansas Catholic Conference
Jerry Slaughter, Kansas Medical Society
Sharlee Mason, American Association of Retired Persons
Dr. Keith Wright, Academy of Family Practice
Dr. Doug Iliff

Others attending: See attached Committee Guest List

HB 2777-Contraceptives Insurance Coverage

Once the television cameras were in place, Chairman Tomlinson introduced the first bill to be heard, **HB 2777,** and recognized Kathleen Sebelius, Commission of the Kansas Insurance Department, as the first conferee. A copy of Commissioner Sebelius' testimony is (Attachment #1) attached hereto nad incorporated into the Minutes by reference. Commissioner Sebelius laid the ground work for the bill which addressed covering contraceptives as a basic health care need for women. The aim is to amend K.S.A. 1999 Supp. 40-2, 103 and 40-19c09 and repeal the existing conditions. There would be a new section 1, 2, 3, 4, 5. Section 6: Statutes application; Section 7: Corporate standard language references; Section 8: Repealer; Section 9: Effective date; Statute book. It was stated that women spend more out-of-pocket expenses for health services than their male counterparts do. One of the biggest expenses is birth control.

Commissioner Sebelius explained the use of birth control "reduces unintended pregnancies." The Commissioner explained the dollar amounts involved included a study by the Alan Guttmacher Institute which stated "that every public dollar spent to provide contraceptive services saved $4.40 in a fund that would have been spent on medical care and social service to women who otherwise have become pregnant." It was stated that contraceptives, over a five-year period will cost women somewhere between $500 and $5800, whereas some women not using contraceptives will more than likely have 4.25 children in this same time frame and cost on the average of $14,663.

The Commissioner covered the "Contraceptives as a "cost effective" alternative." There are approximately 6.3 million unintended pregnancies in the United States each year. "Nationally, 97 percent of all indemnity plan cover prescription drugs," yet only 33 percent of these plans cover contraceptives. The cost to add this coverage to a policy would range from $1.75 to $13.33 for single coverage or $4.80 to $41.06 for family coverage. The employer cost for providing this coverage would be approximately 1 percent of about $1.43 per employee per month. Out-of-pocket expenses are approximately $25. per month. The increase to the

The Commissioner informed the committee that nine states have passed such laws as of last year that will require coverage for all five FDA-approved contraceptive methods. This also includes counseling, exams, insertion and removal. The Commissioner informed the committee of the latest figures for Kansas from the Kansas Health Insurance Information System. These figures were taken from the 1997 and 1998 data. It was stated, "oral contraceptives represented 1 percent of the total paid charges for pharmaceuticals in the KHIIS database, ...the average paid charge per prescription for oral contraceptives was $13.13 and $ 13.81, the average co-pay was $11.73 and $12.18 and total transaction cost for oral contraceptive was $24.86 and $25.99." These figures did not include other forms of contraceptives. The commissioner then stood for questions. Questions were formed by Representatives Boston, Empson and the Chairman. The questions ranged from cost of prescription to additional cost to the policyholder to whose concern and responsibility this would fall on. Final question was by Representative Showalter.

Ms. Barbara Duke, American Association University Women, gave Proponent Testimony, a copy of the testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference. Ms. Duke supported the previous testimony of the Commissioner. There were no questions from the committee.

Ms. Karla Wilmot, Director of Quality Management Planned Parenthood of Kansas and Mid-Missouri, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference. Ms. Wilmot covered much of the same information as Commissioner Sebelius, adding facts and data from her own office with Planned Parenthood. Ms. Wilmot stated that while many of the women they see either are unemployed or have no insurance coverage at all, a large number of the women they see have insurance but come to Planned Parenthood for birth control and contraceptives at a more reasonable price, also many of their policies exclude birth control coverage. Ms. Wilmot explained to the committee that in the '80's the pill ran $10, today even with the slide-scale the pill can run $8 to $17, pharmacy costs can run $19 to $35. Many families must decide between food and the pill, due to the lack of coverage. These prices are for the pill only, other forms of control may run $60 to $600 out-of- pocket, depending on the going market rate.

Ms. Wilmot informed the committee that it was not unusual for women to either delay returning or stop coming in at all due to the inability to pay. Many women become pregnant, not for their irresponsibility but for the lack of funds to pay for their contraceptives. When this happens then the prices increase because women then need a pregnancy test before the next round of pills can be prescribed or receive their next shot of Depo Prevera, or whatever the case maybe.

Ms. Wilmot explained there is also another side to this issue. For many younger women the only time they will see a physician is when they are getting contraception. At that time they will receive some basic preventive health services which will include: cancer screening (Pap smears, breast exams), tests for sexually transmitted diseases, high blood pressure, diabetes, anemia, sickle cell anemia, urinary infections are but just a few. Women miss these exams when they cannot afford the exams for contraceptives.

Finally, she explained that "some forms of hormonal contraceptives help prevent ovarian and endometrial cancers. They are also often used for control of conditions like acne, endometriosis and dysmenorrhea -and sometimes covered by insurance companies for this purpose-but not for the even more important purposed of preventing unintended pregnancies and abortions . . . " Ms. Wilmot closed with stating, "For an estimated $16. More per year per enrollee, health insurance policies could provide all of these benefits to women, their families and society. She then stood for questions. As there were none, the Chairman then recognized Ms. Carla Norcott-Mahany, Kansas Public Affairs Director and Lobbyist Planned Parenthood of Kansas and Mid-Missouri.

Ms. Norcott-Mahany gave Proponent Testimony to the committee. She also presented three (3) other written testimonies from Ms.Cathy Breidenthal, Executive Director, YWCA of Kansas City, Kansas, Ms. Susan Farrell, Executive Director, YWCA, Wichita, Kansas, Travis W. Stembridge, M.D., Vice Chairman, Kansas Section, American college of OB/GYN, Wichita, Kansas. A copy of each of the written testimonies is (Attachments #4, 5, 6, 7) attached hereto and incorporated into the Minutes by reference. Ms. Norcott-Mahany and others also endorsed the bill with Ms. Norcott-Mahany addressing not only the cost of contraceptives to women, not men, but also the fact that Viagra is paid for men by insurance companies by

the means to halt or avoid unintended pregnancies is not. There were no questions from the committee. Representative Phelps addressed a question to Karla Wilmot, while Representative Boston addressed the subject of equity.

With no further Proponent Testimony from the conferees or guests, the Chairman called forward the first Opponent conferee. Mr. Bill Sneed, Health Insurance Association of America, gave the first Opponent Testimony to the committee. A copy of the written testimony is (Attachment #8) attached hereto and incorporated into the Minutes by reference.

Mr. Sneed informed the committee that to begin with, his clients are against insurance mandates in general. They also believe that the new Section1 may create a conflict throughout the bill. They feel that "parity in prescription insurance and contraceptive coverage act of 2000," the argument might arise that the parity would cover all contraceptives as it relates to prescription insurance. They feel that "pure parity" would cover all contraceptives, to those used by women (Page 2, lines 1-2). Mr. Sneed stated "they were unaware of any document that proves that such prescriptions are not paid for by the prescription drug benefit." Mr. Sneed also addressed the study prepared by Dr. Gail A. Jensen and Dr. Michael S. Morrisey regarding these types of mandates. They feel that mandates drive costs up and have the opposite effect on the marketplace. Mr. Sneed said that many of these coverages were readily available to the insured or their employer but may be at an additional cost. The employer has designation of coverage.

It was decided to wait until all of the testimony was in from the opponents and then return to the committee for the question session.

Next to be recognized was Ms. Larry Ann Lower, Kansas Association of Health Plans. Ms. Lower gave Opponent Testimony to the committee. A copy of the written testimony is (Attachment #9) attached hereto and incorporated into the Minutes by reference. Ms. Lower stated her clients are also against mandates and feel this bill mandates coverage for any prescribed drug or device approved by the United States Food and Drug Administration as a contraceptive. She also pointed out, this bill exempts a "religious employer" from having to provide contraceptive coverage to their employees.

Ms. Lower also raised other questions. What devices are proposed to be covered? Why are the employers having choices of coverage for their employees being taken away from them and this coverage mandated to them? What of the insured who would like one type of prescription coverage but not contraceptives coverage? Ms. Lower feels this will drive cost for coverage up and increase the cost of prescriptions as well. Ms. Lower and her clients feel that if there is to be a mandate that the first thing to do is to subject it to the provisions of K.S.A. 1999 Supp. 40-2249a, which requires any new mandate to be tested on the state employees health plan first. Ms. Lower stated that mandates are driving the cost of coverage up further and further with each new mandate, and the types and choices of insurance are becoming fewer and fewer. This completed Ms. Lower's testimony.

Ms. Judy Smith, State Director, Concerned Women for America of Kansas, was the next conferee to speak against the bill. A copy of Ms. Smith's testimony is (Attachment #10) attached hereto and incorporated into the Minutes by reference. Ms. Smith stated that first off the term "contraceptive" and "contraceptive device" is not defined. Ms. Smith pointed out that many of the so called birth control devices or pills are not what they appear to be. The are not against conception, but an action to "prevent implantation by providing a hostile environment for the developing child." Ms. Smith informed the committee that, according to Moore and Persuad, "these hormones prevent implantation, not conception." Ms. Smith stated the bill "should exclude any contraceptive pill or device that would prevent implantation of a fertilized egg on the basis that this is a unique human life." Mr. Smith informed the committee there is a need for a provision for people who would be enrolled that have moral objections or these "abortifacient drugs." She felt language should also include a provision that "nothing in the act shall require an insurer regulated under it to provide coverage for any prescription or contraceptive pill or device if the insurer *or policy holder* objects on religious or moral grounds. She felt that no one should be forced to pay for a policy that contains such coverage if it goes against their moral conscience. Ms. Smith felt providing this type of coverage would do nothing but scale back legitimate coverage and raise costs for all. With this Ms. Smith concluded her testimony before the committee.

back legitimate coverage and raise costs for all. With this Ms. Smith concluded her testimony before the committee.

Mr. Terry Leatherman, Vice-President of Legislative Affairs for the Kansas Chamber of Commerce and Industry. A copy of Mr. Leatherman's Opposing Testimony is (Attachment #11) attached hereto and incorporated into the Minutes by reference. Mr. Leatherman felt there would be a negative impact in regard to the increasing rates with this policy which would be passed on to the policy holder and not absorbed by the insurance industry. Mr. Leatherman informed the committee the hardest hit of these policy holders would be those in small group and individual policies. More increases in policies force more people to drop their insurance coverage. KCCI also feels mandates are an intrusion of government on the private insurance market. He feels the elements of policies should not be developed by lawmakers, but by the insurance companies to meet the needs of the people. Mr. Leatherman also felt the testing procedure passed last session should be implemented rather than imposing it directly on the public sector if this issue is to be pursued.

Ms. Cleta Renyer, Right to Life of Kansas, Inc., gave Opponent Testimony to the committee. A copy of the testimony is (Attachment #12) attached hereto and incorporated into the Minutes by reference. Ms. Renyer felt the bill would be wrong to force to cover drugs they feel are immoral or medically unnecessary, as well as pro-life insurers paying premiums with pro-choice insureds for coverage they feel is morally wrong.

Ms. Beatrice Swoopes, Acting Executive Director, Kansas Catholic Conference, gave Opponent Testimony, to the committee. A copy of her written testimony is (Attachment #13) attached hereto and incorporated into the Minutes by reference. Ms. Swoopes, representing the Roman Catholic Churches and Bishops opposed the bill because it goes against the teachings of the Church. She also informed the committee that the State of Kansas already allows insurance companies to write coverage for the percentage of the population who feel they want or need these coverages. Ms. Swoopes also added their concerns for the rising cost in premiums and these costs being passed on to the consumer. Ms. Swoopes continued on to address the issue of "contraceptive coverage" not being defined in the bill. Many of these pills destroy the embryo and they feel this raises moral concerns about early abortion. Ms. Swoopes said mandating contraceptive coverage, the government increases the pressure for physicians and pharmacists to violate their own consciences. She concluded by stating,"This mandate is seen as an attack on the religious freedom and conscience rights of Catholic and other health care plans, providers, and employers/participants who object to providing or paying for artificial contraception. With this the Opponent Testimony on the bill was concluded and the questions from the committee were opened.

Questions were from Representatives Grant, Cox, Kirk, Empson, Boston, Toelkes, Burroughs, and Showalter. These questions were directed to Mr. Sneed, Mr. Leatherman, Commissioner Sebelius, and to a statement of the Chair by Representative Toelkes.

HB 2708-Health insurance; classifying OB/GYN as a primary care provider **& HB 2735**-Health insurance; requiring insurers to classify physicians who practice obstetrics or gynecology as primary care physicians.

As the material is basically the same the conferees will speak to both bills simultaneously. The first conferee to address the bill was Insurance Commissioner Kathleen Sebelius. A copy of the Proponent Testimony is (Attachment #14) attached hereto and incorporated into the Minutes by reference. Ms. Sebelius gave an overview of the bills and then spoke as though there was one bill which is how I will refer to them in the Minutes. The bill deal with women who want their OB/GYN as their primary physician. With this bill "any health insurer shall classify an obstetrician or gynecologist as a primary care provider."

Commissioner Sebelius informed the committee that should the OB/GYN not be a primary provider, their health insurer would be able to refer the woman to an OB/GYN within the "in-network OB/GYN" for a routine gynecological appointment without requiring the woman to visit her primary provider first. The Commissioner quoted numbers from a California study regarding women and their preference. The commissioner asked, "Why should women be forced to see two doctors when they only need one?"

The Commissioner informed the committee, that "Maryland became the first state to classify an OB/GYN as a primary care physician (PCP), and allow direct access. She went on to state that since that time 39 other

stated have also enacted the OB?GYN law. However, each in state, the law varys. She continued on that, "Some laws require plans to permit qualified OB/GYNs as primary care physicians; others allow unlimited access, or access for routine gynecological and pregnancy service only, without a referral."

The Commissioner then stood for questions. There were no questions asked of the Commissioner.

The next conferee to address the bill was Ms. Sharlee Mason, Volunteer Member of AARP, in Kansas. Ms. Mason offered Proponent Testimony to the committee. A copy of the testimony is (Attachment #15) attached hereto and incorporated into the Minutes by reference. Ms. Mason informed the committee, "managed care has become the dominant delivery system in the United States. A major legislative trend in the statehouses in the past 5 years has been give women who are enrolled in managed care plans direct access to OB/GYN services by either not requiring a woman to first get a referral from her primary care provided or by allowing a woman to designate an OB/GYN as her primary care physician." Ms. Mason felt that many women considered their OB/GYN as their primary care giver already and therefore does not understand why they must go through another primary provider to see that person. Ms. Mason and her organization feel that, "women should have direct access to obstetricians/gynecologists for routine gynecological care; and that women should be allowed to designate these physicians as their primary care providers." With this, Ms. Mason stood for questions. There were none.

Mr. Jerry Slaughter, Kansas Medical Society, was the next conferee on the bill. Mr. Slaughter gave Proponent Testimony to the committee, of which a copy is (Attachment #16) attached hereto and incorporated into the Minutes by reference.

Mr. Slaughter stated that they too support the bill, and feels this is consistent with what is already happening. Mr. Slaughter used pediatrics as an example of this stating "....pediatricians do serve as primary care physicians for children all across this state." They feel that by making it a law for Kansas would be a good step. He also suggested the committee may want to add language that sets out what a pediatric physician is. He stated a pediatrician is a physician who specializes in pediatrics. Mr. Slaughter continued on to state, many OB/GYNs probably would not want to serve as a primary care physician, nor would they want to provide all of the services that would be required of them in this capacity. Mr. Slaughter said they do support direct access as the bill points out and perhaps change the language to read "obstetrician or gynecologist means, a physician who specializes in obstetrics or gynecology. Mr. Slaughter stood for questions. There were none.

With all of the Proponent Testimony having been given the Chairman then recognized Dr. Keith Wright, President of the Kansas Academy of Family Physicians. A copy of Dr. Wright's testimony is (Attachment #17) attached hereto and incorporated into the Minutes by reference. Dr. Wright felt that designating a specialty of the primary physicians did not mean the would necessarily fulfill the role of primary care physicians need or should play in a community or health care. He felt that women's health care is their total well being not just one or two things. A primary physician should be capable of treating and dealing with the entire body, multiples of health issues and they need to be able to recognize the problem and refer to the correct specialist. With this Dr. Wright stood for questions. There were none.

Mr. William Sneed, Health Insurance Association of America, was the next conferee. A copy of his testimony is (Attachment #18) attached hereto and incorporated into the Minutes by reference. He stated his clients' were unaware of any obstetricians or gynecologists that were requesting their doctor be instilled as their primary provider. Their titles or specialties alone should be information enough that they do not want to be primary care physicians. Mr. Sneed reminder the committee that a women could already visit the OB/GYN at least two times without requiring they see a primary care provider first. Care must be medically necessary and that is already in place. Mr. Sneed informed the committee that this mandate would have a direct cause and effect on premiums, "as it will allow visits with the specialist without regard to the gatekeeping provisions found in most managed care situations." Mr. Sneed also informed the committee that the term "health insurer" is not defined and the bill would then affect the managed care programs and indemnity type health insurance as well.

Mr. Sneed explained to the committee that to mandate benefit laws and in reality they simply drive up the costs of the premiums and have the total affect on the marketplace. Mr. Sneed stood for questions of which there were none at this time. Mr. Sneed's testimony also included the "Mandated Benefit Laws and Employer-Sponsored Health Insurance" report.

Dr. Douglas Iliff, was the next conferee to offer Opponent testimony before the committee. A copy of the Iliff testimony is (Attachment #19) attached hereto and incorporated into the Minutes by reference. Dr. Iliff presented his opinion as to why the bill should not be mandated. Dr. Iliff also gave his credentials to the committee of which included a teaching medicine. Dr. Iliff is a general practitioner. Dr. Iliff gave a thorough explanation of why an OB/GYN should not be the primary provider, stating the general or family practitioner is able to evaluate every organ of the system in the human body "with regard to the most common presenting problems." These physicians may be asked about skin rashes, pneumonia, blood pressure problems, cholesterol problems, sore ears, obesity, bed wetting, pink eye or even an abnormal pap smear. An OB/GYN is unable to consult with a patient on these matters. Even though they are "valuable members of the medical team," they are simply not primary care physicians. An OB/GYN is like a pathologist, radiologist, surgeon, neurologist or any other medical professional that is specializing. They know about their field, but a family or general practitioner has knowledge and training that included the entire body. After completing his testimony, Dr. Iliff stood for questions.

Ms. Larry Ann Lower, Kansas Association of Health Plans, followed Dr. Iliff, to give Opponent testimony. A copy of the testimony is (Attachment # 20) attached hereto and incorporated into the Minutes by reference. Ms. Lower explained to the committee that currently HMO'S allow women to visit an OB/GYN for routine care once a year without a referral. This visit is a covered benefit, because it is what the marketplace wants, not because it mandated as such by the government. KAHP requests the committee and the legislature allows the insurance industry to meet the demands of the marketplace instead of enacting more mandates that are sure to cost insurance premiums to rise.

Ms. Lower concluded in stating, "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 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 to determine its financial impact." Ms. Lower stood for questions. With this Ms. Lower stood for questions. Representatives Myers, Vining and Showalter presented their questions to Dr. Iliff.

Meeting was adjourned at 5:21 p.m.

The next meeting will be held February 15, 2000 at 3:30 p.m.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: Feb 10, 2000

NAME	REPRESENTING
Carrie Donovan	KAID
Barbara Duke	AAUW
Maria A. Espinoza	Federico Consulting
Bruce Dimmitt	Independent
Bill Sneed	NFIB
Larrie Ann Lower	KAHP
Cheryl Allard	HealthNet
Seth Wagoner	Rep. Lynn Jenkins
Brent Hubin	Ks Pharmacists Assoc.
[illegible]	AARP
Cleta Reniger	Right to Life of Ks
Barbara Haldeman	Kansans for Life
[illegible]	CNA
[illegible]	KAHP
[illegible]	KAHP
M Chantel Long MD	KAFP
[illegible]	KAFP
[illegible]	KAFP
Anne Spiess	Peterson Public Affairs Group

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: February 10, 2000

NAME	REPRESENTING
Carolyn Middendorf	Ks St Ds Assn
Nina Atencio	Bottenberg & Assoc.
Tom Bell	Ks Hosp - Assn.
John Peterson	Ks Governmental Consulting
Janet K. Stamper	Kansas NOW
Sandra DeCoursey	KS Ins. Dept.
Kathleen Sebelius	KS Ins Dept
Aaron Small	KS Ins. Dept

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: HB 2777 – Equity in Prescription Coverage and Contraceptive Coverage

DATE: February 10, 2000

Mr. Chairman and members of the Insurance Committee:

Thank you for the opportunity to discuss with you the provisions of HB 2777. Contraception is a basic health care need of women. Using contraceptives allows women and their partners to limit the number of children to desired family size, control timing of pregnancy, and prevent unintended pregnancy. Many benefit....unfortunately, women pay for it. Women spend an average of 68 percent more than men in out-of-pocket expenses for health care services. One of the biggest contributors to that expense is birth control.

Reduces Unintended Pregnancies – Costs Involved

One of the reasons cited for women taking birth control is to prevent unintended pregnancy. The Alan Guttmacher Institute found that every public dollar spent to provide contraceptive services saved $4.40 in fund that would have been spent on medical care and social service to women who would otherwise have become pregnant. The Family Connection reports savings of an average of $7.70 in California for every public dollar spend on contraceptive services. Public dollars spent on contraception services in California saved an estimated 136,800 unintended pregnancies each year. According to the Family Connection, unplanned pregnancies are frequently unhealthy pregnancies. A healthy pregnancy costs between $3,000 and $5,000. A pre-term baby can cost upwardly of $61,000. The average pregnancy costs about $14,000. First and second term abortions cost between $250 and $2,000. The pill costs $308-$358 a year. The American Journal on

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Public Health states that contraceptive costs over five years for a women will between $500 and $5800, while a woman not using contraception is likely to have 4.25 children during this time period at an average cost of $14,663.

Contraceptives a "cost effective" alternative

In 1995, data from the National Survey of Family Growth indicated that approximately 31 percent of all live births were associated with unintended pregnancy. In 1997, a Utah study indicated that in a one-day sample of 16,635 women enrolled in the WIC program revealed 54 percent reported that their pregnancies were unplanned. Estimates show that more than 200,000 Utah women are at risk of unintended pregnancy and 276,000 women in Kansas are at-risk for an unintended pregnancy. According to National Family Planning and Reproductive Health Association, 6.3 million pregnancies occur in the United States each year are unintended. Almost half of these pregnancies end in abortion. Most studies agree that contraceptives are a "cost effective" alternative compared to pregnancy or abortion.

Contraceptive coverage varies among insurers

Contraceptive coverage varies among insurers and types of health plans. According to information gathered from the National Conference of State Legislatures, about 93 percent of HMOs, 70 percent of point of service networks (POS), 50 percent of preferred provider organizations (PPO), and 50 percent of indemnity plans coverage the cost of some contraception services.

Nationally, 97 percent of all indemnity plan cover prescription drugs, only 33% cover contraceptives. In Kansas, some insurers provide coverage for contraceptives, other insurers do not provide this coverage. Information gathered in 1998 by the Kansas Insurance Department provides the cost to add contraceptive coverage if the prescription drug coverage didn't provide for contraceptive coverage. Those costs range from $1.75 - $13.33 for single coverage and $4.80 to $41.06 for family coverage.

Employer cost for providing coverage

According to the NCSL, a study conducted in 1998 concluded that an employer's cost for providing coverage for contraceptives would mean an increase of about one percent which is about $1.43 per month per employee. The increase to the employee would be about 35 cents. The out-of-pocket cost for oral contraceptives is approximately $25 per month.

What other states are doing

Mr. Chairman and members of the committee, I have attached information on what other states are doing in this arena. Twenty-one states have considered the equity in prescription coverage issue. Nine states passed laws just last year that require coverage for all five FDA-approved methods of contraceptives, as well as counseling, exams, insertion and removal.

Kansas specific information

On the Kansas front, attached is Kansas sensitive data from the Kansas Health Insurance Information System (KHIIS). Oral contraceptives represent approximately one percent of the total paid charges for pharmaceuticals in the KHIIS database in 1997 and 1998. The average paid charge per prescription for oral contraceptives was $13.13 in 1997, and $13.81 in 1998. The average co-pay prescription for oral contraceptives was $11.73 in 1997 and $12.18 in 1998. The total transaction cost for oral contraceptives was $24.86 in 1997 and $25.99 in 1998. Other forms of birth control including intra-uterine devise and contraceptive cap represent too few claims to be analyzed. A chart is presented to show you the costs by age group, as well as the averages paid by the insurer, the insured and total cost of a contraceptive prescription.

Closing

In closing, we have reviewed a lot of facts and figures about contraception, and most agree that contraceptives are a "cost effective" alternative compared to pregnancy or abortion. Women pay more out-of-pocket costs than men, and these costs are for reproductive health care. This is an important topic, one being discussed in other

legislatures throughout our nation. In Kansas, some of the insurance plans, while they offer prescription coverage, many do not cover prescription contraceptives, or they are offered at further cost to women. Contraception is a basic health care need of women, and by passing HB 2777 out of your committee favorably, you will do the right thing for women in Kansas.

BILL SUMMARY: HB 2777

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

NEW SECTION 1: This act shall be known as the parity in prescription insurance and contraceptive coverage act of 2000.

NEW SECTION 2:

a. "insured" means the beneficiary of any insurance company, fraternal benefit society, etc. authorized to transact health insurance business in this state.

b. "health insurance plan" means any hospital or medical expense policy, health, hospital, etc. contract offered by an employer or any certificate issued under any such policies, contracts or plans. Health insurance plan does not include policies or certificates covering any specified disease, specified accident or accident only coverage, credit, dental, etc. as defined by KSA 40-2227 and amendments thereto, vision car or any other limited supplemental benefit nor to any medicare supplement insurance policy as defined by the commissioner of insurance by rule and regulation, etc, under which benefits are payable with or without regard to fault, whether written on a group, blanket, or individual basis.

c. "outpatient contraceptive services" means consultations, examinations, procedures and medical services, provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

d. "Commissioner" means the commissioner of insurance

NEW SECTION 3:

a. Every health insurance plan that is delivered, issued, approved, etc. on or after July 1, 2000, which provides for prescription drugs on an outpatient basis or outpatient services provided by a health care professional:

1. shall provide coverage for any prescribed drug or device approved by the US FDA for contraceptive

2. shall provide coverage for the insertion/removal of such device and any necessary medical examination

NEW SECTION 4:

a. Impose any deductible, coinsurance, other cost-sharing or waiting period in relation to benefits for prescription contraceptive drugs or devices under a health insurance plan, unless deductible, coinsurance, cost-sharing, etc. or waiting periods for other prescription drugs is no greater than

such deductibles, coinsurance, etc. for other prescription drugs or devices covered under insurance plan;

b. impose any deductible, coinsurance, etc. in relation to benefits for outpatient contraceptive services under a health insurance plan, unless deductible, coinsurance, etc. is no greater than such deductibles, etc. for other outpatient services covered under the health insurance plan;

c. deny to any individual or insured person eligibility, or continued eligibility to enroll or to renew coverage under the terms of the plan because of the individual's or insured's use or potential use of items or services covered in accordance with requirements of this act;

d. provide monetary payments/rebates to a covered person to encourage such insured to accept less than minimum protections available under this act;

e. penalize or otherwise reduce or limit the reimbursement of a health care professional because of such professional prescribed contraceptive drugs/devices, or provided contraceptive services in accordance with this act;

f. provide any incentive, monetary or otherwise, to any health care professional to induce such professional to withhold from an insured contraceptive drugs, devices or other contraceptive services.

NEW SECTION 5:

a. notwithstanding any other provision of this act, a religious employer may request a health insurance contract plan without coverage for FDA approved contraceptive methods that are contrary to the employer's religious tenets. If a religious employer so requests, a health insurance plan contract shall be provided without coverage for contraceptive methods. This section shall not be construed to deny an enrollee coverage of, and timely access to, contraceptive methods.

b. "religious employer" is an entity for which each of the following is true

1. the inculcation of religious values is the purpose of the entity;
2. the entity primarily employs persons who share the religious tenets of the entity
3. the entity primarily serves persons who share its religious tenets
4. the entity is a nonprofit organization described by Section 6033(a)(2)(A)I or iii, of the federal internal revenue code of 1986, as amended

c. every religious employer that invokes the exemption shall provide written notice to prospective enrollees prior to enrollment in the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

SECTION 6: Statutes application.

SECTION 7: Corporate standard language references

SECTION 8: Repealer

SECTION 9: Effective date: Statute book

Health Insurance Coverage for Contraceptives Health Care Program

Updated January 28, 2000

Women spend about 68 percent more in out-of-pocket expenses for health care than men. One of the biggest contributors to that expense is birth control. Birth control is the most widely used prescription drug of women aged 15 to 44. Health insurance coverage varies greatly among insurers and types of health plans. About 93 percent of HMOs, 70 percent of point of service networks, 50 percent of preferred provider organizations and 50 percent of indemnity plans cover the cost of some the reversible contraception services: pills, IUDs, diaphragms, Norplant and Depo Provera. Only 39 percent of HMOs and 15 percent of indemnity plans routinely cover all five methods. The momentum to support coverage of contraceptives increased when the male impotence drug, Viagra, entered the market and insurers covered its cost. States have been mandated to cover family planning services for Medicaid beneficiaries since 1973.

A study conducted in 1998 concluded that an employer's cost for providing coverage for contraceptives would mean an increase of about 1 percent which is about $1.43 per month per employee. The increase to the employee would be about 35 cents. The out-of-pocket cost for oral contraceptives is approximately $25 per month. The cost of childbirth without complications is between $3,000 and $5,000.

As of January 28, 2000, 13 states-Alaska, Delaware, Hawaii, North Carolina, Missouri, New York, Oklahoma, Rhode Island, South Carolina, South Dakota, Vermont, Washington and Wisconsin-have bills introduced or carried over from last session that include a mandated coverage or offering of coverage for contraceptives.

Many states (more than half) debated this issue in their legislatures in 1999, with laws enacted in **Connecticut, Hawaii, Georgia, Maine, New Hampshire, Nevada, North Carolina and Vermont**. In 1999, **Maryland** became the first state to pass legislation specifically requiring private insurers to provide comprehensive coverage for contraceptives if they covered the cost of prescription drugs. **Virginia** passed a law in 1997 that requires health insurers to offer employers the option of including coverage in the benefit plans for their employees but the law does not mandate coverage. **Texas** has an administrative rule requiring insurers to cover contraceptives if they cover prescription drugs.

A few states have laws or rules that require insurers in the individual and small employer market to offer a basic or standard plan that includes coverage for some or all forms of contraception. A number of states have rules that deal with contraceptive coverage or laws that deal with the topic in some way.

The following is a list of state activity in this area.

***State actions:* (* indicates those states that have passed broad contraceptive coverage mandates)**

California requires health service plans to provide basic health care services including medically necessary voluntary family planning services. Code Regs. Tit 10 § 1300.67(f)(2) (1998).

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***Connecticut** requires insurers that offer prescription drug coverage to include coverage for contraceptives. Allows for a religious exemption. 1999 HB 5502, Public Act No. 99-79

***Georgia** requires insurers that offer prescription drug coverage to include contraceptives. 1999 HB 374

Hawaii requires all health insurers, mutual benefit societies, and health maintenance organizations to cease excluding contraceptive services and supplies from coverage by repealing the provision of such coverage as an employer option; exempts certain employers from providing coverage for contraceptive health care services and supplies that are contrary to the employer's religious tenets. (SB 822, Act 267) In 1994 Hawaii mandated that coverage for contraceptive services and FDA-approved contraceptive prescription drugs and devices be offered to employers if pregnancy related services are covered. This is not a mandate for coverage. 1994, 432:1-604.5, 431:10A-116.6
http://www.capitol.hawaii.gov/session1999/bills/sb822_.htm

Idaho requires insurers in the individual and small employer market to offer a basic, standard and catastrophic plan that includes coverage for some or all forms of contraception. (This is decided by a committee and there is no citation.)

Iowa requires insurers in the individual and small employer market to offer a basic and standard plan that includes coverage for some or all forms of contraception. Admin. Code r. 191-71.14(6)(513B), 191-75.10(4)(513C) (Nov. 5, 1997)

Kentucky requires insurers in the individual and small employer market to offer a standard plan, among other plans, that includes coverage for some or all forms of contraception. (The now defunct Health Policy Board created the standard plan requirements--the Department of Insurance is now working on clarifying the requirements of the standard plan. No citation available)

***Maine** requires insurers that provide coverage for prescription drugs and outpatient medical services to provide coverage for all prescription contraceptives and outpatient contraceptive services. Allows for a religious exemption. 1999 S.P. 389, L.D. 1168 P.L. 341

***Maryland** passed legislation specifically requiring private insurers to provide comprehensive coverage for contraceptives. Allows for a religious exemption. The law was enacted in 1998. HB 457, Chapter 117, Md. Health-General Code§19-706 and Md. Insurance Code §15-826

Minnesota law (62D.02 subdivision 8, 62D.04 subdivision 1) requires HMOs to provide "comprehensive health maintenance services" which is interpreted by rule that the HMO provide coverage for prescription drugs including coverage for contraceptives. (MN rules 4685.0100 subpart 5 and 4685.0700 subpart 3)

***Nevada** requires insurers that offer prescription drug coverage to include coverage for contraceptives. Allows for a religious exemption. 1999 AB 60, Chapter 689A.

***New Hampshire** requires insurers that provide coverage for outpatient services to provide coverage for outpatient contraceptive services. The law also requires insurers that provide coverage for prescriptions to cover all prescription contraceptive drugs and devices. There is no religious or conscious based exemption. 1999 SB 175, Chapter 252

http://www.state.nh.us/gencourt/bills/99bills/sb0175.html

New Jersey requires insurers in the individual and small employer market to offer a standard plan that includes coverage for some or all forms of contraception. Admin. Code tit.11, § 20 App. Exh. D (Sept. 8, 1998); tit. 11§ 21 App. Exh. F (Oct. 19, 1998).

New Jersey rules also require HMOs to provide voluntary family planning services. Admin. Code tit. § 38-5.4 (June 1, 1998)

New Mexico rules require managed care plans providing coverage for "comprehensive basic health care services" to cover voluntary family planning services including contraceptive procedures and services. Admin. Code tit. 13, §§ 10.13.7.18, 10.13.7.19, 10.13.9.8 (March 16, 1997)

***North Carolina** requires insurers that offer prescription drug coverage to include coverage for contraceptives and outpatient contraceptive services. Allows for a religious exemption. 1999 SB 90. § 58-3-176 http://www.ncga.state.nc.us/html1999/bills/ratified/senate/sbil0090.full.html

Ohio requires health insurance corporations to provide basic health services, including medically necessary voluntary family planning services. §§ 1751.01 (A)(7)

***Texas** Administrative Code prohibits insurers from excluding coverage for oral contraceptives if all other prescription drugs are covered. 1978, 28 Texas Admin. Code. Chap. 21.404(3)

***Vermont** requires health insurance plans to provide coverage for contraceptives is they cover prescription drugs. 1999 H 189, Sec. 1.8 V.S. A.§ 4099c

Virginia requires insurers that provide coverage for prescription drugs to offer and make available coverage for FDA-approved contraceptive drugs or devices. 1997, § 38.2-3407.5:1

West Virginia law requires HMOs to provide or make available basic health care services that encompass coverage for contraceptives. 1996, 1997 33-25A-2(1), (11)

Wyoming rules require HMOs to provide voluntary family planning services. Wyoming Insurance Regulations, Chapter 13, section 7, subsection cii(B)

Selected References:

National Abortion and Reproductive Rights Action League Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights, Eighth Edition*. Washington, D.C.: NARAL, 1999

Deborah Senn, *Reproductive Health Benefits Survey: A Report by the Washington State Office of the Insurance Commissioner.* Olympia, Washington: Washington State Insurance Department, 1998.

Jacqueline E. Darroch, *Cost to Employer Health Plans of Covering Contraceptives: Summary, Methodology and Background.* June 1998. Obtained from http://www.agi-usa.org/

Planned Parenthood Federation of America, Inc., *The Equity in Prescription Insurance and Contraceptive Coverage Act.* Obtained from http://www.plannedparenthood.org/Library/birthcontrol/Equity.html

Liz Kaiser and Molly Stauffer, *Women's Health: A Legislative Overview of Selected Mandates.* Washington D.C.: National Conference of State Legislatures, 1999.

This compilation may not be exhaustive of all state activities.

Health Program Home Page

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KEY

The drug categories below contain commonly used medications your doctor may prescribe. You should present this member formulary to your physician at each office visit.

$ = Relative cost per day's worth of therapy
Please note this may effect your copayment
***** = Generic available
otc = Available without prescription
# = Maintenance Drug: up to a 34 day supply or 100 units, whichever is greater

Exclusions may vary depending upon your group benefits.

PRIOR AUTHORIZATION REQUIRED

- Avonex
- Betaseron
- Copaxone
- Dexedrine
- Desoxyn
- Growth Hormones: Protropin, Humatrope, and Nutropin
- Imitrex
- Stadol NS

ACNE

Topical

$	Emgel,* T-Stat*	$$$	clindamycin*
$	Desquam-E	$$$	Sulfacet-R
$	Desquam-X	$$$$	Benzamycin

Note: Certain oral agents under BACTERIAL in the **INFECTIONS** section are also commonly used for treatment of acne.

ALLERGY

Antihistamines

$	chlorpheniramine* otc
$	diphenhydramine* otc
$	cyproheptadine*
$	hydroxyzine*
$$	Tavist*
$$$	Allegra
$$$$	Claritin

Nasal Inhalers

$$$	Atrovent NS
$$$	Beconase
$$$	Rhinocort
$$$$	Beconase AQ
$$$$	Nasarel
$$$$	Flonase

Antihistamines/ Decongestants

$	Deconamine SR
$	Dura-Tap/PD
$	Dura-Vent/A
$	Dura-Vent/DA
$	Nolamine
$	Poly-Histine D
$$	Trinalin Repetabs
$$$$	Claritin-D

ANGINA CHEST PAIN (#)

Nitrates

Oral

$	isosorbide dinitrate*
$	Nitroglyn
$	Nitrostat
$$$	Imdur

Patches

$$$	Nitro-Dur
$$$	Transderm-Nitro

Note: Certain agents in the BETA BLOCKERS and CALCIUM BLOCKERS classes are often used for prevention of chest pain. See HIGH BLOOD PRESSURE for listing of these agents

ANXIETY

$	diazepam*	$$$	alprazolam*
$	lorazepam*	$$$$	Buspar

ARTHRITIS

(Osteo and Rheumatoid)
See **PAIN** category

ASTHMA

Bronchodilators

Inhalers

$	Alupent
$	Maxair, Maxair Autohaler
$$	Ventolin,*
$$$$	Serevent *(Maintenance use only)*

Oral

$	metaproterenol*
$$	Ventolin*
$$$	Volmax

Steroids

Inhalers

$$$	Beclovent
$$$	Flovent 44, 110
$$$$	Flovent 220

Oral

$	prednisone*
$$$	Prelone

Theophyllines

$	Theo-Dur
$	Theo-X
$	Uniphyl

Miscellaneous

$$$	Tilade
$$$$	Accolate
$$$$$$	Intal

BIRTH CONTROL (Up to 3 cycles per copay)

$	Levlen, Tri-Levlen	$$	Ovcon
$	Norethin*, Norinyl*	$$$	Alesse
$$	Demulen	$$$	Brevicon*
$$	Desogen	$$$	Estrostep FE
$$	Loestrin, Loestrin FE	$$$	Tri-Norinyl
$$	Lo/Ovral	$$$	Triphasil
$$	Nordette		

COUGH AND COLD

$	Dura-Vent	$	Guiatuss AC syrup*
$	Exgest LA*	$	Histussin-D
$	Fenesin, Fenesin DM	$	Histussin HC
$	Guai-Vent/PSE	$	Poly-Histine CS
$	Zephrex LA	$	Poly-Histine DM

DEPRESSION

$	amitriptyline*	$$$	Serzone
$	doxepin*	$$$	Wellbutrin, Wellbutrin SR
$	imipramine*	$$$$	Paxil
$	Desyrel*	$$$$$	Effexor
$$	desipramine*	$$$$$	Prozac
$$$	nortriptyline*	$$$$$	Zoloft

DIABETES

Oral

$	chlorpropamide*	$$$	Glucotrol XL
$	glyburide*	$$$$	Glucophage
$	tolazamide*	$$$$	Precose
$	tolbutamide*	$$$$$$	Rezulin

Insulins

$$$	Lilly	$$$	Novo

Other

$$$$	Accu-chek Advantage Test Strips
$$$$	Accu-chek Instant Test Strips
$$$$	Glucometer Elite Test Strips
$$$$	Glucometer Encore Test Strips

EYE

$	Pilocar	$$$$	Acular
$$	Fluor-Op	$$$$	Betagan
$$	Ophthaine	$$$$	Betimol
$$	Vasocon A	$$$$	FML-S
$$$	Inflamase	$$$$	Livostin
$$$	Inflamase Mild	$$$$	Ocuflox
$$$	Ocufen	$$$$	Pred-G
$$$	Polytrim	$$$$$	Alphagan
$$$	Propine	$$$$$	Betoptic
$$$	Vasocidin	$$$$$	Xalatan

HEART FAILURE (#)

$	Lanoxin

Note: Certain agents in the DIURETICS and ACE INHIBITORS classe are commonly used for the treatment of heart failure. See HIGH BLOOD PRESSURE for a listing of these agents.

HIGH BLOOD PRESSURE (#)

Ace Inhibitors

$	Capoten*
$	Monopril
$$	Zestril
$$$	Capozide

Angiotensin II Blockers

$$$	Diovan

Calcium Blockers

$	verapamil*
$$	Calan SR
$$$	Adalat CC
$$$$	Cardizem CD
$$$$	diltiazem*
$$$$	nifedipine*
$$$$	Norvasc

Vasodilators

$	hydralazine*
$	prazosin*
$$	Cardura
$$$	Hytrin

Beta Blockers

$	atenolol*
$	propranolol*
$$	propranolol LA*
$$	Tenoretic
$$	Toprol XL
$$	Visken*
$$$	Corgard*
$$$	Trandate
$$$	Ziac

Diuretics (water pills)

$	chlorthalidone*
$	furosemide*
$	hydrochlorothiazid
$	spironolactone*
$$	Demadex
$$$	indapamide*

HIGH BLOOD CHOLESTEROL (# HYPERCHOLESTEROLEMIA

$	nicotinic acid* otc	$$$$	Colestid Granules
$$	Lescol	$$$$	Questran
$$$	Pravachol		*(cans cost preferre*
		$$$$$	Colestid Tablets

INFECTIONS

Bacterial

$	amoxicillin*	$$	Duricef
$	ampicillin*	$$$	Minocin*
$	cephalexin*	$$$	Pediazole*
$	Dynapen*	$$$$	Cefzil
$	doxycycline*	$$$$	Macrobid
$	Erythrocin, EryPed	$$$$	PCE Dispertab
$	penicillin VK*	$$$$$	Augmentin
$	SMZ-TMP*	$$$$$	Biaxin
$	sulfisoxazole*	$$$$$	Ceftin
$	tetracycline*	$$$$$	Zithromax

KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Secretary

February 10, 2000

Ms. Linda DeCoursey
Director of Government Affairs
Kansas Insurance Department
410 SW 9th Street
Topeka, Kansas 66612-1678

Dear Linda:

Thank you for the information request regarding the costs associated with oral contraceptives. The Kansas Department of Health and Environment (KDHE), the statistical agent for the Kansas Insurance Department (KID), maintains a database of summary and claim level data collected from the top 20 insurers of Kansas residents based on premium volume reported to KID. Despite its breadth, this database may not be representative of the typical insured Kansas resident.

Data is collected only on claims of the privately insured. The Kansas Health Insurance Information System (KHIIS) excludes data on participants in Employee Retirement Income Security Act (ERISA), Medicaid and Medicare plans. The population represented in KHIIS may differ significantly from those excluded from KHIIS and from the general population. Therefore, extrapolation of these data outside this context is limited.

Health Care Information staff have queried the KHIIS to provide preliminary information which may be useful. Please review the items below and the supporting tables which are attached. I hope this information will be useful to you.

- Oral contraceptives represent approximately one percent of the total paid charges for pharmaceuticals in the KHIIS database in 1997 and 1998.
- The average paid charge per prescription for oral contraceptives was $13.13 in 1997 and $13.81 in 1998, a difference of 5.2%.
- The average copay per prescription for oral contraceptives was $11.73 in 1997 and $12.18 in 1998, a difference of 3.8%.

CENTER FOR HEALTH AND ENVIRONMENTAL STATISTICS
Office of Health Care Information

Landon State Office Building
900 SW Jackson, Suite 904
PHONE (785) 296-8627

Topeka, KS 66612-1290
FAX (785) 368-7118

HC

KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Secretary

- The average total transaction cost for oral contraceptives was $24.86 in 1997 and $25.99 in 1998, a difference of 4.5%.

- Other forms of birth control including the intra-uterine device and contraceptive cap represent too few claims in this database to be analyzed.

Sincerely,

Elizabeth W. Saadi (pf)

Elizabeth Saadi, Director
Health Care Information

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Office of Health Care Information

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Topeka, KS 66612-1290
FAX (785) 368-7118

Average Cost of Oral Contaceptives by Average Paid Charge, 1997			
Contraceptive	Average Paid Charge per Prescription	Average Copay per Prescription	Average Transaction Amount
Brevicon	$17.77	$3.68	$21.45
Levora	$16.73	$8.45	$25.18
Norethin 1/35 E	$15.95	$8.85	$24.80
Estrostep Fe	$15.70	$10.30	$25.99
Ovcon 50	$15.58	$11.99	$27.57
Nelova 1/50 M	$14.81	$7.50	$22.31
Modicon	$14.55	$12.23	$26.78
Loestrin 21 1/20	$14.50	$11.74	$26.23
Alesse	$14.31	$9.85	$24.16
Loestrin FE 1.5/30	$14.27	$11.67	$25.95
Loestrin 21 1.5/30	$14.16	$11.88	$26.04
Genora 1/50	$14.14	$13.50	$27.64
Loestrin FE 1/20	$13.88	$12.26	$26.14
Demulen 1/35	$13.82	$11.53	$25.36
Genora 1/35	$13.74	$10.96	$24.70
Demulen 1/50	$13.63	$13.96	$27.59
Ovcon 35	$13.60	$11.91	$25.51
Ortho Tri-Cyclen	$13.59	$11.27	$24.86
Ortho Cyclen	$13.52	$11.23	$24.75
Ortho-Novum 1/50	$13.39	$10.76	$24.15
Lo/Ovral	$13.00	$11.90	$24.89
Ortho-Cept	$12.89	$11.84	$24.73
Tri-Norinyl	$12.89	$10.87	$23.76
Levlen	$12.84	$11.34	$24.18
Ortho-Novum 7/7/7	$12.78	$11.95	$24.72
Zovia 1/35	$12.61	$11.32	$23.93
Ortho-Novum 1/35	$12.55	$11.64	$24.19
Triphasil	$12.51	$11.92	$24.43
Desogen	$12.45	$11.17	$23.63
Ortho-Novum	$12.24	$14.10	$26.34
Nelova 1/35	$12.11	$10.71	$22.82
Nordette	$12.09	$12.20	$24.29
Tri-Levlen	$11.97	$11.85	$23.82
Norinyl 1/35	$11.49	$9.78	$21.27
Norinyl 1/50	$10.44	$11.74	$22.18

Average paid charge per prescription represents the average amount an insurance company pays for each contraceptive prescription.

Average copay per prescription represents the average out of pocket expense to the insured consumer.

Average transaction amount represents the average total cost of a prescription.

Average Cost of Oral Contaceptives by Name, 1997			
Contraceptive	Average Paid Charge per Prescription	Average Copay per Prescription	Average Transaction Amount
Alesse	$14.31	$9.85	$24.16
Brevicon	$17.77	$3.68	$21.45
Demulen 1/35	$13.82	$11.53	$25.36
Demulen 1/50	$13.63	$13.96	$27.59
Desogen	$12.45	$11.17	$23.63
Estrostep Fe	$15.70	$10.30	$25.99
Genora 1/35	$13.74	$10.96	$24.70
Genora 1/50	$14.14	$13.50	$27.64
Levlen	$12.84	$11.34	$24.18
Levora	$16.73	$8.45	$25.18
Lo/Ovral	$13.00	$11.90	$24.89
Loestrin 21 1.5/30	$14.16	$11.88	$26.04
Loestrin 21 1/20	$14.50	$11.74	$26.23
Loestrin FE 1.5/30	$14.27	$11.67	$25.95
Loestrin FE 1/20	$13.88	$12.26	$26.14
Modicon	$14.55	$12.23	$26.78
Nelova 1/35	$12.11	$10.71	$22.82
Nelova 1/50 M	$14.81	$7.50	$22.31
Nordette	$12.09	$12.20	$24.29
Norethin 1/35 E	$15.95	$8.85	$24.80
Norinyl 1/35	$11.49	$9.78	$21.27
Norinyl 1/50	$10.44	$11.74	$22.18
Ortho Cyclen	$13.52	$11.23	$24.75
Ortho Tri-Cyclen	$13.59	$11.27	$24.86
Ortho-Cept	$12.89	$11.84	$24.73
Ortho-Novum	$12.24	$14.10	$26.34
Ortho-Novum 1/35	$12.55	$11.64	$24.19
Ortho-Novum 1/50	$13.39	$10.76	$24.15
Ortho-Novum 7/7/7	$12.78	$11.95	$24.72
Ovcon 35	$13.60	$11.91	$25.51
Ovcon 50	$15.58	$11.99	$27.57
Tri-Levlen	$11.97	$11.85	$23.82
Tri-Norinyl	$12.89	$10.87	$23.76
Triphasil	$12.51	$11.92	$24.43
Zovia 1/35	$12.61	$11.32	$23.93

Average paid charge per prescription represents the average amount an insurance company pays for each contraceptive prescription.

Average copay per prescription represents the average out of pocket expense to the insured consumer.

Average transaction amount represents the average total cost of a prescription.

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Average Cost of Oral Contaceptives by Average Paid Charge, 1998			
Contraceptive	Average Paid Charge per Prescription	Average Copay per Prescription	Average Transaction Amount
Nelova 1/50 M	$18.20	$8.91	$27.11
Levora	$17.42	$7.65	$25.08
Zovia 1/50	$16.73	$8.86	$25.59
Modicon	$16.54	$11.85	$28.39
Genora 1/50	$16.11	$8.79	$24.89
Ovcon 35	$15.74	$11.98	$27.71
Estrostep Fe	$15.18	$12.06	$27.24
Norinyl 1/35	$15.13	$10.13	$25.26
Norinyl 1/50	$15.09	$9.27	$24.35
Norethin 1/50 M	$14.91	$5.00	$19.91
Loestrin 21 1/20	$14.87	$12.11	$26.98
Loestrin FE 1.5/30	$14.80	$11.82	$26.62
Norethin 1/35 E	$14.72	$8.07	$22.79
Alesse	$14.60	$11.08	$25.68
Nordette	$14.53	$11.57	$26.10
Brevicon	$14.50	$4.42	$18.92
Demulen 1/35	$14.49	$11.50	$25.99
Loestrin FE 1/20	$14.43	$12.57	$27.00
Ortho-Novum 1/50	$14.21	$10.77	$24.98
Lo/Ovral	$14.11	$12.30	$26.41
Ovcon 50	$14.02	$14.77	$28.79
Ortho Tri-Cyclen	$13.93	$12.12	$26.05
Ortho Cyclen	$13.65	$12.49	$26.15
Triphasil	$13.52	$12.25	$25.77
Loestrin 21 1.5/30	$13.48	$13.32	$26.80
Mircette	$13.46	$12.29	$25.75
Tri-Norinyl	$13.46	$11.50	$24.95
Demulen 1/50	$13.43	$15.26	$28.69
Ortho-Cept	$13.39	$12.57	$25.96
Nelova 1/35	$13.35	$8.43	$21.78
Tri-Levlen	$13.34	$12.07	$25.42
Trivora	$13.25	$10.77	$24.02
Ortho-Novum 7/7/7	$13.12	$12.87	$25.99
Ortho-Novum 1/35	$13.10	$11.86	$24.96
Levlen	$12.96	$13.08	$26.05
Desogen	$12.58	$12.06	$24.64
Genora 1/35	$12.14	$10.82	$22.96
Ovral	$11.62	$18.22	$29.84
Zovia 1/35	$11.17	$13.16	$24.33
Ortho-Novum	$11.00	$13.82	$24.82
Necon 1/50	$10.59	$8.54	$19.12
Necon 1/35	$10.53	$8.73	$19.25
Genora 0.5/35	$9.94	$16.02	$25.96

Average paid charge per prescription represents the average amount an insurance company pays for each contraceptive prescription.

Average copay per prescription represents the average out of pocket expense to the insured consumer.

Average transaction amount represents the average total cost of a prescription.

Average Cost of Oral Contaceptives by Name, 1998			
Contraceptive	Average Paid Charge per Prescription	Average Copay per Prescription	Average Transaction Amount
Alesse	$14.60	$11.08	$25.68
Brevicon	$14.50	$4.42	$18.92
Demulen 1/35	$14.49	$11.50	$25.99
Demulen 1/50	$13.43	$15.26	$28.69
Desogen	$12.58	$12.06	$24.64
Estrostep Fe	$15.18	$12.06	$27.24
Genora 0.5/35	$9.94	$16.02	$25.96
Genora 1/35	$12.14	$10.82	$22.96
Genora 1/50	$16.11	$8.79	$24.89
Levlen	$12.96	$13.08	$26.05
Levora	$17.42	$7.65	$25.08
Lo/Ovral	$14.11	$12.30	$26.41
Loestrin 21 1.5/30	$13.48	$13.32	$26.80
Loestrin 21 1/20	$14.87	$12.11	$26.98
Loestrin FE 1.5/30	$14.80	$11.82	$26.62
Loestrin FE 1/20	$14.43	$12.57	$27.00
Mircette	$13.46	$12.29	$25.75
Modicon	$16.54	$11.85	$28.39
Necon 1/35	$10.53	$8.73	$19.25
Necon 1/50	$10.59	$8.54	$19.12
Nelova 1/35	$13.35	$8.43	$21.78
Nelova 1/50 M	$18.20	$8.91	$27.11
Nordette	$14.53	$11.57	$26.10
Norethin 1/35 E	$14.72	$8.07	$22.79
Norethin 1/50 M	$14.91	$5.00	$19.91
Norinyl 1/35	$15.13	$10.13	$25.26
Norinyl 1/50	$15.09	$9.27	$24.35
Ortho Cyclen	$13.65	$12.49	$26.15
Ortho Tri-Cyclen	$13.93	$12.12	$26.05
Ortho-Cept	$13.39	$12.57	$25.96
Ortho-Novum	$11.00	$13.82	$24.82
Ortho-Novum 1/35	$13.10	$11.86	$24.96
Ortho-Novum 1/50	$14.21	$10.77	$24.98
Ortho-Novum 7/7/7	$13.12	$12.87	$25.99
Ovcon 35	$15.74	$11.98	$27.71
Ovcon 50	$14.02	$14.77	$28.79
Ovral	$11.62	$18.22	$29.84
Tri-Levlen	$13.34	$12.07	$25.42
Tri-Norinyl	$13.46	$11.50	$24.95
Triphasil	$13.52	$12.25	$25.77
Trivora	$13.25	$10.77	$24.02
Zovia 1/35	$11.17	$13.16	$24.33
Zovia 1/50	$16.73	$8.86	$25.59

Average paid charge per prescription represents the average amount an insurance company pays for each contraceptive prescription.

Average copay per prescription represents the average out of pocket expense to the insured consumer.

Average transaction amount represents the average total cost of a prescription.

Oral Contraceptive Costs by Age Group

	1997			1998		
Age Group	Average Paid Charge per Prescription	Average Copay per Prescription	Average Tranaction Amount	Average Paid Charge per Prescription	Average Copay per Prescription	Average Tranaction Amount
13 to 17	$13.81	$11.22	$25.03	$12.13	$10.86	$22.99
18 to 29	$12.98	$11.86	$24.84	$13.69	$12.28	$25.97
30 to 39	$13.21	$11.66	$24.87	$13.72	$12.38	$26.10
40 to 49	$13.45	$11.66	$25.11	$14.29	$11.68	$25.97

Average paid charge per prescription represents the average amount an insurance company pays for each contraceptive prescription.

Average copay per prescription represents the average out of pocket expense to the insured consumer.

Average transaction amount represents the average total cost of a prescription.

Testimony before the House Insurance Committee

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN

Kansas

Barbara M. Duke, State Board Member, Kansas AAUW; President, Kansas Choice Alliance. Phone: 785-749-0786

February 10, 2000

Chairman Tomlinson and members of the House Committee on Insurance:

On behalf of Kansas AAUW and the other organizations that make up the Kansas Choice Alliance, I thank you for this opportunity to speak in support of H.B. 2777 providing insurance coverage for prescription contraceptives.

We support access to safe and affordable family planning and reproductive health services for all women. Contraception and related outpatient services are basic health care for women and should be covered by health insurance policies as are other basic health care needs. Access to the full range of contraceptive care ensures that women are able to choose methods that are the most appropriate for their health and lifestyle in order to determine when to have children.

We support legislation that would ensure equitable coverage of contraceptive drugs, devices, and medical services in private health insurance.

Contraceptives have a proven track record of preventing unintended pregnancy, reducing the need for abortion, and enhancing the health of women and children. In any single year 85 percent of sexually active women not using a contraceptive method become pregnant. In contrast, only 3 to 6 percent of oral contraceptive users become pregnant in a year. Reducing unintended pregnancy is key to reducing the number of abortions because almost half of unintended pregnancies end in abortion.

Though contraception is basic health care for women, many private insurers do not treat it as such.

- Women of reproductive age spend 68 percent more in out-of-pocket health care cost than men of the same age.. Much of the gender gap in expenses is due to supplies and services related to reproductive health.

- Almost 5 million women nationwide who have private insurance spend more than 10 percent of their income on out-of-pocket medical expenses. Contraceptive coverage would relieve Kansas women of the double burden of paying for private insurance and reproductive health services.

Legislation is needed to establish parity for contraceptive prescriptions and related medical services within the context of coverage already guaranteed by each insurance plan. We support H.B. 2777 so women will no long have to pay more for basic reproductive health care.

Barbara Duke

Hse Ins Comm
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Planned Parenthood®
of Kansas and Mid-Missouri

Testimony by

Karla Wilmot, RNC, WHNP, MSN
Director of Quality Management
Planned Parenthood of Kansas and Mid-Missouri

before the
Insurance Committee
of the
Kansas House of Representatives

on February 10, 2000

in Support of House Bill 2777

4401 W. 109th St., Suite 200 • Overland Park, KS 66211 • (913) 312-5100

HSE Ins Comm
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HB 3
3-1

Good Afternoon. Thank you for the opportunity to offer testimony here today in support of House Bill 2777. My name is Karla Wilmot, and I am the Director of Quality Management for Planned Parenthood of Kansas and Mid-Missouri. I am currently responsible for oversight of the delivery of family planning services and related health care in our thirteen health centers, four of which are in Kansas. I am licensed as an Advanced Registered Nurse Practitioner in both Missouri and Kansas. Until last year, I worked as a clinician in one of our family planning clinics and still do so on occasion. In these positions, I have had ample opportunity to observe and understand how the affordability of prescription contraceptives—including the availability of insurance coverage—affects the ability of our clients to use effective family planning practices, prevent unintended pregnancies and protect their health.

While Planned Parenthood serves women who may be unemployed or have no insurance coverage at all, we also see large numbers of women who have insurance coverage but choose to come to Planned Parenthood for reasonably-priced birth control and contraceptive services because their insurance excludes coverage of these essential health services.

Birth control is expensive. Even in 1985, when a month's supply of contraceptive pills cost ten dollars, I remember my own dilemma of having to choose between buying food or buying birth control because of a lack of insurance coverage. Now "the pill" is more expensive. Even at Planned Parenthood, where we serve some clients on a sliding fee basis and try to keep costs as low as possible for others, pill prices range from $8 to $17 per month. At a pharmacy they cost approximately $19-$35. Prices for other forms of reversible prescription contraceptives may be less expensive on a per month basis, but patients using Depo Provera (an injectable contraceptive that lasts three months), Norplant (a contraceptive implant that provides protection for 5 years), the IUD (an interuterine device which can remain in place for 10 years) and barrier

methods such as the diaphragm, must come up with a large up-front, out-of-pocket investment that ranges (at market prices) from $60 for Depo Provera to $600 for an IUD or Norplant. For women without insurance to cover at least a portion of those fees, these prescription forms of birth control—the most reliable forms of birth control—are often beyond their means. Or, they are forced to forego other basic necessities of life in order to prevent an unintended pregnancy. Our mission at Planned Parenthood is to make these services as inexpensive as possible. But even then, some women struggle to afford them.

It is not unusual for women to delay coming back for their next pack of pills or their next Depo injection until they can afford it. Often, the next time you see these patients is when they come in for a pregnancy test. Many crisis pregnancies are a result, not of irresponsibility, but of a lack of available funds for contraception.

Every single week, someone in our clinics faces a crisis pregnancy as a direct result of inability to pay for contraception. One recent example: A woman walked into our Lawrence clinic for a pregnancy test. She normally received care from her private physician, where her insurance covered her annual exam but not her pills. When I gave her the positive result from her pregnancy test, she burst into tears. Just a month before, she was taking her birth control pills. She stopped her pills because she couldn't afford both her pills and Christmas for her kids.

Even those who are lucky enough not to have become pregnant while delaying their injection will have increased the cost of their next visit because they will have to pay, in addition to birth control, for a pregnancy test before they can resume Depo Provera.

Lack of insurance coverage not only causes many women to choose the most expensive form of birth control—that is, oral contraceptives because a packet of pills requires the smallest out-of-pocket expense—lack of coverage may also induce women to use a less effective or more

inappropriate form of contraceptive for their particular circumstances. This is true because women without coverage are more apt to choose the pill—but also because, when there is contraceptive coverage, it is often limited only to oral contraceptives.

For younger women and teens, Depo Provera or Norplant are often better choices because their long-term protection avoids the risks from human error inherent in a method that requires remembering to take a pill every day without fail. The most appropriate birth control for older women who already have families may be Norplant or the IUD which provide long-term protection without surgery or having to make a permanent decision about future fertility. For smokers over 35 years old and for those women with high blood pressure, all other FDA-approved contraception methods are safer than the pill. Women should not have to make decisions about matters so central to their health and the well-being of themselves and their families based on whether or not their insurance covers a particular method of birth control.

There is another major health issue involved in the failure to provide insurance coverage for birth control. Especially for younger women, their only regular contact with the health care system is likely to be for purposes of getting contraception. When they see a clinician for that purpose, they are, as a part of that visit, going to receive some other basic preventive health services including: cancer screening tests like Pap smears and breast exams; testing and treatment—if indicated—for sexually transmitted infections; and general health exams that might uncover conditions such as high blood pressure, anemia, sickle cell anemia, urinary tract infections or diabetes. When women can't afford to come in for contraception, they are likely to skip this preventive health care all together.

And finally, there are collateral benefits involved in the regular use of birth control. Some forms of hormonal contraceptives help prevent ovarian and endometrial cancers. They are

also often used for control of conditions like acne, endometriosis and dysmenorrhea—and sometimes covered by insurance companies for those purposes—but not for the even more important purposes of preventing unintended pregnancies and abortions, and for spacing pregnancies for healthier pregnancies, babies and families.

For an estimated $16.00 more per year per enrollee, health insurance policies could provide all of these benefits to women, their families and society. Isn't it worth it? I urge you to vote for HB 2777.

Planned Parenthood®
of Kansas and Mid-Missouri

Testimony by

Carla Norcott-Mahany
Kansas Public Affairs Director and Lobbyist
Planned Parenthood of Kansas and Mid-Missouri

before the
Insurance Committee
of the
Kansas House of Representatives

on February 10, 2000

in Support of House Bill 2777

4401 W. 109th St., Suite 200 • Overland Park, KS 66211 • (913) 312-5100

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Good afternoon, Representative Tomlinson and members of the House Insurance Committee. My name is Carla Norcott-Mahany. I am the Kansas Public Affairs Director and Lobbyist for Planned Parenthood of Kansas and Mid-Missouri. We appreciate this opportunity to speak on behalf of House Bill 2777, which would help increase the availability of contraceptive drugs and devices prescribed by doctors for women in Kansas. We applaud the efforts of Commissioner Sebelius for bringing this important matter to the attention of the legislature this session, as we appreciate the opportunity provided by this hearing to speak publicly in support of it. This is a compassionate, common sense approach to solving one of the most implacable public health challenges in Kansas as in the rest of the country: unplanned pregnancy.

There is compelling and abundant information as to why this bill should become law and join the ten states that have enacted similar proposals in the last two years: Maryland, Georgia, Vermont, Maine, Nevada, Connecticut, North Carolina, Hawaii, New Hampshire and California. (Virginia, Montana, New Mexico, West Virginia and Texas have previously adopted some measure of contraceptive equity through legislation or regulation). Among the most persuasive arguments for the passage of HB 2777 is the fact that it proposes nothing more than fundamental fairness. It would give more Kansans the tools necessary to make the right and responsible decisions for themselves and their families. Rejecting this bill would be 'penny wise and pound foolish.' When it comes to birth control, the resulting cost of doing little or nothing far outweighs the cost of doing something.

We've done some number crunching from census data available for the midwest. In Kansas there are many different types of families with a variety of personal and financial circumstances, but I'd like to talk about the "average" Midwest family today. The total monthly income required to meet basic needs is $2316. This includes housing, food and clothing, travel, and child care. Health care costs $158 a month, and out of pocket health insurance cost is an additional $84 a month. Men in the Midwest make $2436 on average per month, and women make $1940 on average per month – quite a bit less than the $2316 considered adequate to meet basic needs.

I give you this information to make the point that many families with jobs and health care don't make enough to cover all the basics. When women must pay for contraceptive coverage in addition to the pressing financial demands of their families, they may have to decide between 'bills and pills,' or they may opt for the less expensive—and less effective—methods of contraception. In fact, a Kaiser Family Foundation Survey on Insurance Coverage of Contraception recently found that 74% of American women of reproductive age say contraceptive coverage is a factor in deciding which method of contraception to use.

The typical American woman spends 90% of her reproductive life seeking to avoid pregnancy. The average couple, without adequate birth control, faces the possibility of at least four pregnancies every five year period. At the same time, the same people, despite making insurance premiums every month, are denied a crucial tool for maintenance of their personal and family's well-being and economic stability. Less than 20% of large group fee-for-service plans and less than 40% of HMOs routinely cover all five major reversible methods of contraception.

There is some irony in the fact that those same plans will cover the consequences of unplanned pregnancy – including pre-natal care, post-natal care, and childbirth – which totals no less than $4,300 given a complication-free birth. These are costs that the insurance industry is willing to shift to other premium holders and purchasers. The additional costs in the case of women forced to leave the workforce to care for an unplanned child – general assistance, Medicaid, nutritional services – are shifted to the taxpayer.

I would like to note that not all insurance companies oppose this legislation, because they recognize the indisputable benefit of ensuring client access to contraceptives. Large self-insured groups, including Sprint and Kansas state employees, have some contraceptive coverage.

Opponent insurance companies raise the specter of runaway mandates. Across the country, the mandate label is a familiar and convenient scapegoat. It is currently even more controversial in Kansas due to our new anti-mandate law. However, if test-track requirements were removed today, the "mandate" label would still be a rallying cry for opponents to equitable contraceptive coverage.

You may hear today that the price of mandates is far too costly; that there is a direct relationship between mandates and the growing number of uninsured Americans; that is, the more mandates a state imposes, the greater the burden on employers to provide health insurance and, therefore, fewer workers will have access to insurance coverage. This argument would make more sense if the concern about mandates also held true about men's reproductive health care. However, a price the insurance industry has been quite willing to pay is for Viagra, the relatively new male impotence drug. As Washington Post columnist Judy Mann put it in 1998 when this new drug came on the market at $10 per pill, "Insurance companies have decided to cover Viagra's cost in less time than it takes most men to get a dinner date." The main quibbles have been how often to pay for Viagra, and whether various states will use Medicaid funds to pay for Viagra for poor men. It should also be noted that insurance covers about 73 percent of men using more established impotence treatments – without needing to be prodded by the state via mandates.

I have already referred to a 1998 report from the Kaiser Family Foundation, which undertook an exhaustive and comprehensive "National Survey on Insurance Coverage of Contraception." Attached is one of the charts provided by the Foundation to summarize their data, but there are 11 in all:

Chart 1 - Most Americans Are Unaware of the Contraceptive Coverage Proposal in Congress
Chart 2 – Most Americans Support Requiring Health Insurance to Cover Contraceptives
Chart 3 – Privately Insured Also Support Contraceptive Coverage
Chart 4 – Americans Support Contraceptive Coverage Even If Costs Rise
Chart 5 – Privately Insured Support Contraceptive Coverage Even If Costs Rise
Chart 6 – Most Americans Think All Prescription Contraceptives Should Be Covered
Chart 7 – Most Privately Insured Think All Prescription Contraceptives Should Be Covered Too
Chart 8 – Most Americans Say Contraceptive Coverage Is a Factor in Deciding Which Method to Use
Chart 9 – Most Privately Insured Say Contraceptive Coverage Is a Factor in Deciding Which Method to Use
Chart 10 – American More Mixed on Coverage of Viagra than Prescription Contraceptives
Chart 11 – Privately Insured Tend to Support Viagra Coverage

This survey conducted by the Kaiser Family Foundation found that 75 percent of Americans 18 or older support adding contraceptive coverage to insurers' pharmaceutical coverage, and this

support soars to 88 percent among women of reproductive age. Seventy-eight percent of those Americans would be willing to pay an additional $1 to $5 a month, as would 88 percent of women 18 to 64. Sixty-four percent of the privately insured would be in favor if they had to pay $15 or $20 more a month.

It is difficult to understand why male impotence remedies are an easy 'sell' to insurance companies but prevention of unwanted pregnancy requires a mandate by this Committee, the House, the Senate and the Governor.

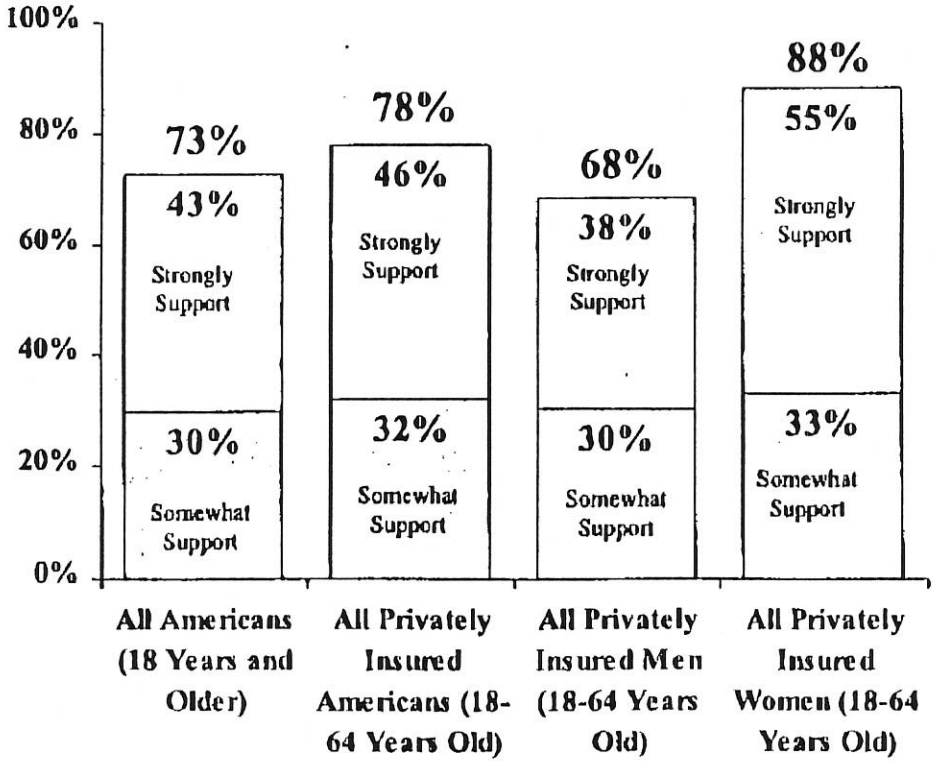
Planned Parenthood supports HB 2777 because it is a common sense step toward ensuring that every child is wanted. Over 90% of our resources, both staff and money, go to prevention activities so people can responsibly choose whether or when to bring children into the world: birth control for men and women, annual gynecological exams for women including pap smears and breast exams, diagnosis and treatment of sexually transmitted diseases, and follow up for abnormal pap smears. When 60% of pregnancies are unplanned and over 50% of insurance plans fail to offer any contraceptive coverage, we can only bring attention to this lack of common sense, and urge you to support HB 2777, a step in the right direction for Kansas women. Thank you.

CHART 5

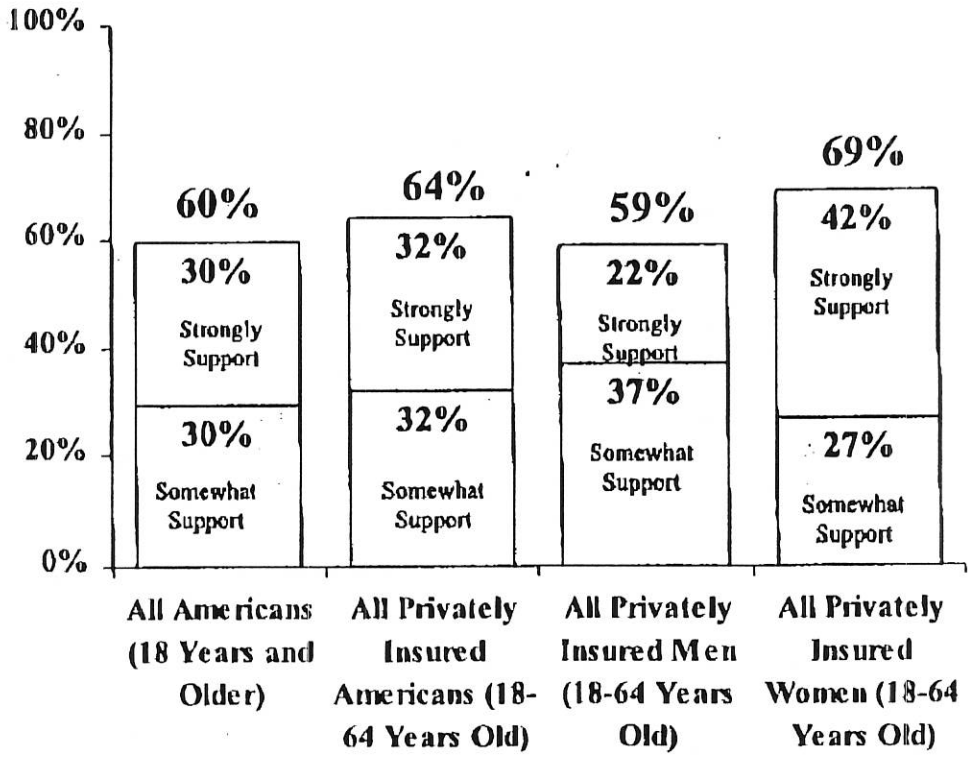
Privately Insured Support Contraceptive Coverage Even If Costs Rise

Percent of Privately Insured Who, Support Adding Contraceptives to Prescription Coverage If:..

"...the average cost individuals pay for health insurance could increase by **$1 to $5 per month**."



"...the average cost individuals pay for health insurance could increase by **$15 to $20 per month**."



Source: Kaiser Family Foundation National Survey on Insurance Coverage of Contraception, Conducted May 22-26, 1998.

Equity in Prescription Insurance and Contraceptive Coverage

More than half of all pregnancies in the U.S. are unintended, and half of all unintended pregnancies end in abortion. Contraceptives have a proven track record of enhancing the health of women and children, preventing unintended pregnancy, and reducing the need for abortion. However, although contraception is basic health care for women, far too many insurance policies exclude this vital coverage. This failure is costly, both for insurers who may have to pay for either maternity care or abortion, as well as the families whose physical and financial well-being is threatened by unintended pregnancy and lack of access to equitable coverage for contraceptives.

While plans routinely cover other prescriptions and outpatient medical services, contraceptive coverage is meager or nonexistent in many insurance policies.

- Half of indemnity plans and PPOs, 20 percent of Point of Service (POS) networks, and 7 percent of HMOs cover *no* reversible contraception.
- Even plans that do provide *some* coverage typically do not cover all of the five most commonly used reversible contraceptive methods (oral contraceptives, the IUD, diaphragm, Norplant and Depo Provera). Less than 20 percent of traditional indemnity plans and PPOs and less than 40 percent of POS networks or HMOs routinely allow women to choose among these give contraceptive methods.
- Coverage of prescription drugs in general usually does not even include coverage for oral contraceptives, the most commonly used reversible contraceptive method in the United States. Although 97 percent of typical indemnity policies cover prescription drugs in general, only 33 percent include oral contraceptives in that coverage. This leaves two-thirds of typical indemnity plans covering "prescription drugs" but not the prescription so many women need access to—oral contraceptives.

Contraception is basic health care for women, and a critical contributor to improved maternal and child health.

- Ready access to contraceptive services increases the likelihood that the estimated 12 million Americans contracting sexually transmitted infections each year will be diagnosed and treated.
- As they help women avoid unplanned pregnancies, contraceptive services help make "planned pregnancies" possible. A study of 45,000 women suggests that women who used family planning services in the two years before conception were more likely to receive early and adequate prenatal care.
- The National Commission to Prevent Infant Mortality estimated that 10 percent of infant deaths could be prevented if all pregnancies were planned; in 1989 alone, 4,000 infant lives could have been saved.

Insurers have relied on women and their families paying out of pocket for contraceptive services and supplies, forcing financial decisions that may result in the use of less effective or less medically appropriate contraception methods.

- Women of reproductive age currently spend 68 percent more in out-of-pocket health care costs than men. Much of the gender gap in expenses is due to reproductive health-related supplies and services.
- The more effective forms of contraception are generally also the most expensive, often costing hundreds of dollars at the outset of patient use. Women and their families who must pay out of pocket may well opt for less expensive and sometimes less effective methods, thus increasing the number of unintended pregnancies.
- Cost analyses for bills at the state level have shown that if health insurance policies were to include coverage for these contraceptive supplies, annual cost increases would be minimal, only $16 per enrollee.

The correlation is clear. Contraception prevents unintended pregnancy and reduces the need for abortion.

- In any single year, 85 of 100 sexually active women not using a contraceptive method become pregnant. In contrast, of 100 oral contraceptive users, only between 3 and 6 percent become pregnant in a year.
- Because the likelihood of pregnancy is so great if contraception is not used, the 10 percent of American women at risk of unintended pregnancy who do not use contraception account for 53 percent of all unintended pregnancies.
- Reducing unintended pregnancy is key to reducing the number of abortions; almost half of unintended pregnancies end in abortion.

YWCA
of Kansas City, Kansas

1017 North 6th Street
Kansas City, KS 66101
(913) 371-1105
Fax (913) 371-3251
ywca-kck@ywca-kck.org

February 9, 2000

Testimony in Support of
HB 2777

The YWCA of Kansas City, Kansas is in support of the proposed contraceptive equity legislation that would require private health insurance companies to cover prescription contraceptives in their benefit plans to the extent that they cover other prescription medications.

Our approach to prevention of unwanted pregnancies in the community begins in the 4th grade with abstinence-based education and moves to a more comprehensive approach with older teens, particularly those that are pregnant and parenting. Our YWCA is part of a bi-state collaboration, Healthy Start 11, providing case management and outreach in order to reduce infant mortality. We are also involved in a School-to Work initiative at Wyandotte High School that encourages pregnant and parenting teens to complete their education and gain marketable skills. Lack of access to contraception to prevent unwanted pregnancies contributes to teens' inability to complete their education and acquire the skills necessary to become contributing members of the community. Young women who use family planning services are more likely to receive early and adequate prenatal care, which also decreases low birth rates and infant death.

The more effective methods of birth control are often the most expensive which discourages use by teens and young women who are economically challenged in our community. With the extremely high birth rates to teens in Wyandotte County, we need to encourage access to and use of family planning services through coverage of prescription contraceptives in order to reduce the resultant stresses on support systems, families and the community.

Cathy Breidenthal
Executive Director
YWCA Of Kansas City, Kansas

girls inc.

United Way

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YWCA
Wichita

1111 N. St. Francis
Wichita, Kansas 67214
(316) 263-7601
(316 267-SAFE
Fax: (316) 263-7503

February 4, 2000

To: Kansas House Committee on Insurance

From: Susan Farrell, Executive Director

Regarding bill #2777

We urge you to support this bill in order to help create more equity in prescription insurance and contraceptive coverage for women. This is long overdue and has been a tragedy to have overlooked this discriminatory practice against women of child-bearing age.

Susan Farrell

HSE INS Comm
2-10-00
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Travis W. Stembridge, M. D.
Vice Chairman
Kansas Section
551 N. Hillside, Suite 540
Wichita, KS 67214

The Honorable Robert Tomlinson
Chair, House Insurance Committee
House of Representatives
State Capitol
Topeka, KS 66612

Dear Representative Tomlinson:

This letter is in support of House Bill 2777. The Kansas Section of the American College of Obstetricians and Gynecologists would ask your committee's support on House Bill 2777 in regard to contraceptive equity. As I am sure you know, this Bill addresses an issue that constitutes a gender equity issue. Women have significantly higher out-of-pocket medical costs than men do and much of this is related to contraceptive use (which men benefit from significantly also).

Coverage of contraceptives is restricted by many insurance plans in ways that coverage for other drugs approved by the FDA is not restricted.

At least fifty percent (50%) of pregnancies in the United States are unintended. Access to contraception enhances the reduction of intended pregnancies and may actually help reduce the number of elective abortions, as well as the number of fetal deaths. Access constitutes a critical preventative measure.

Although the health care insurance industry often states that coverage of contraceptives would increase costs significantly, I think the savings experienced on maternity care, newborn care, and childcare would more than offset any increase in costs. Even if costs did increase slightly, approximately eighty percent (80%) of the American public is willing to bear these increased costs in order to get these drugs covered appropriately. This position is also supported by a study from the Institute of Medicine in 1995.

Contraceptive coverage is strongly supported by the American College of Obstetricians and Gynecologists (ACOG) at the national level and as I initially reported to you is strongly supported by the Kansas Section of ACOG.

Many other states are now requiring coverage or are in the process of passing legislation to require coverage. I hope that your committee will see fit to recommend passage of this Bill for the people of Kansas.

Thank you very much for your attention to this matter. If you have any questions, I would be happy to speak with you at any time about this issue.

Sincerely,

Travis W. Stembridge, M.D.
Vice Chairman
Kansas Section
American College of OB/GYN

TWS/lt

Hlth Ins Comm
2-10-00
#7

7-1

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. 2777

DATE: February 10, 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. 2777. 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. 2777.

First, we believe new section 1 may, by its very nature, create a conflict throughout the bill. Inasmuch as it proclaims the act to be known as "the parity in prescription insurance and contraceptive coverage act of 2000," one might argue that the parity would be for all contraceptives as it relates to prescription insurance. Thus, although not completely certain within the bill, pure parity would require insurers to cover all contraceptives, i.e., condoms, oral

One AmVestors Place
555 Kansas Avenue, Suite 301
Topeka, KS 66603
Telephone: (785) 233-1446
Telecopy: (785) 233-1939
wsneed@pwvs.com

HSE Ins Comm
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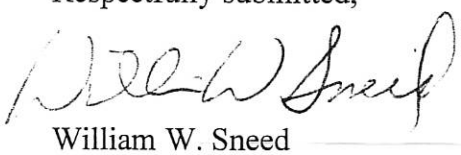
contraceptives, etc., and when look at page 2, lines 1-2, it would appear to be limited to those contraceptives utilized by women.

Secondly, if we are actually talking about those contraceptives that can only be purchased via a prescription, and the individual has a health insurance place which provides coverage for prescription drugs, we are unaware of any documents that proves that such prescriptions are not paid for by the prescription drug benefit.

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. 2777. 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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8-2

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

Michael A. Morrisey, Ph.D.
Lister Hill Center for Health Policy
University of Alabama-Birmingham

555 13th Street NW · Suite 600 East · Washington DC 20004-1109 · 202-824-1600 · http://www.hiaa.org

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.

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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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

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.

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

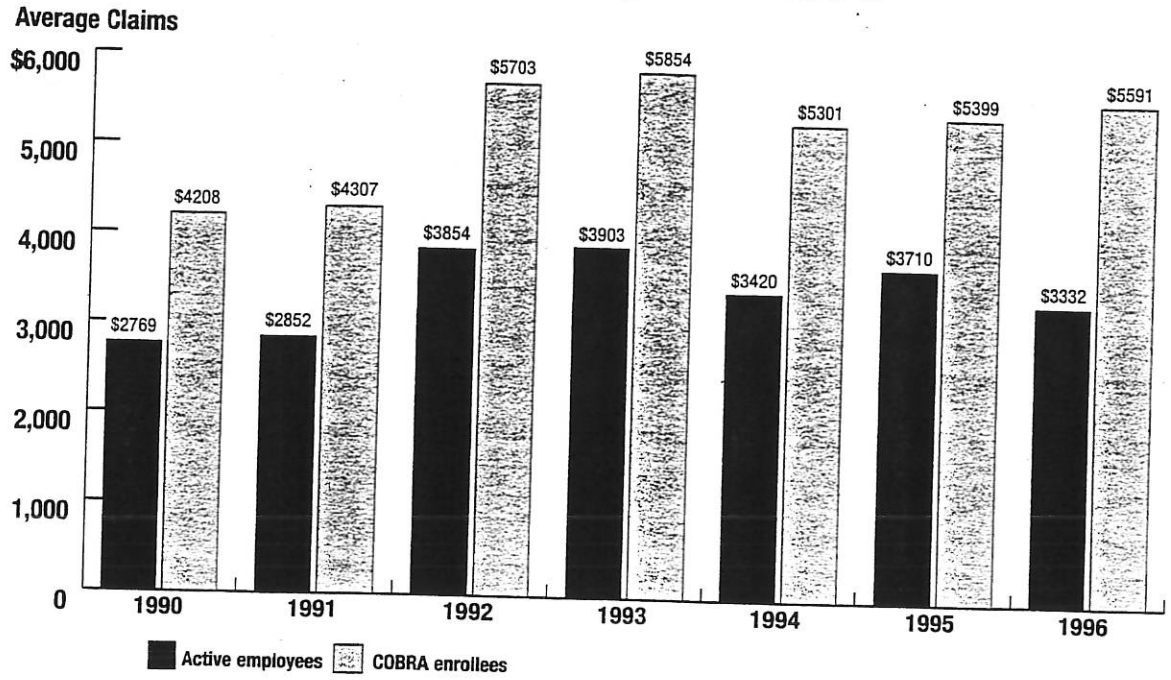

FIGURE 3

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].

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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.

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].

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

1206 SW 10th Street
Topeka, KS 66604

785-233-2747
Fax 785-233-3518
kahp@kansasstatehouse.com

Testimony before the
House Insurance Committee
The Honorable Robert Tomlinson, Chairman
Hearings on HB 2777
February 10, 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 2777. This bill mandates that a health insurer plan which provides coverage for prescription drugs must provide coverage for any prescribed drug or device approved by the United States food and drug administration as a contraceptive. The bill allows an exemption for a "religious employer."

This bill raises many concerns and questions. For example, what contraceptive devices is the Commissioner proposing that health plans cover? Why are we eliminating the choice of employers who may not desire to purchase contraceptive coverage and therefore may choose to eliminate prescription coverage or all together eliminate health insurance for their employees. What about the individuals who would like to purchase prescription drug coverage but do not need or desire to purchase contraceptive coverage. This legislation will without question increase the cost of prescription drug coverage, first by requiring health plans to provide coverage for all prescribed contraceptives, regardless of formularies, and by requiring that all employers purchase this benefit.

In conclusion, the KAHP would request that you not pass this legislation for the numerous reasons stated above. 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 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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Beverly LaHaye
Chairman

Judy Smith
State Director

TESTIMONY TO THE HOUSE COMMITTEE ON INSURANCE: H.B. 2777 **February 10, 2000**

Chairperson Tomlinson and Members of the Committee:

Thank you for the opportunity to speak against this bill concerning insurance, providing coverage for contraceptives and contraceptive devices. I would like to speak against this bill for several reasons:

- The term "contraception" and "contraceptive device" is not defined. Many of the so-called birth control pills and devices are not contra (against) conception at all. Their mechanism of action is to prevent implantation by providing a hostile environment for the developing child. Implantation occurs several days after actual conception. As early as 1952, Planned Parenthood's Dr. Abraham Stone noted that "any mechanical, chemical or "measures designed to prevent implantation" fall into a different category. Here there is a question of destroying a life already begun." [*Research in Contraception: A Review and Preview, Nov. 24-29, 1952, Family Planning Association of India, 101]*
- "Contraception" could include the "morning after pill", which in many cases does not prevent ovulation but again provides a hostile environment for the developing embryo. According to Moore and Persaud, "these hormones prevent implantation, not conception. Consequently, they should not be called contraceptive pills. Conception occurs but the blastocyst does not implant. It would be more appropriate to call them "Contraimplanatation pills". Because the term abortion refers to a premature stoppage of a pregnancy, the term abortion could be applied to such an early termination of pregnancy." [*The Developing Human: Clinically Oriented Embryology. 6th edition,p.532: London]*
- According to an embryology textbook, "human pregnancy begins with the fusion of an egg and a sperms…after fertilization, the preimplatation embryo remains extremely vulnerable. The "morning after pill, with its high estrogen content, alters the endometrium so that implantation fails to occur." [Bruce M. Carlson, *Human Embryology and Developmental Biology: St. Louis, MO; Mosby: 1994]* The bill should exclude any contraceptive pill or device that would prevent implantation of a fertilized egg on the basis that this is a unique human life.
- There is no provision for those people that would be enrolled in the plan that have a conscientious moral objection to these abortifacient drugs. Additional language is needed providing that nothing in the act shall require an insurer regulated under it to provide coverage for any prescription or contraceptive pill or device if the insurer *or policy holder* objects on religious or moral grounds. Conscience protection should accommodate and respect these concerns. No one should be forced to pay for or provide procedures to which they object based on religious or moral belief. The Kansas Legislature should not be forcing members of insurance plans that provide prescription services to pay for contraceptive devices when it is clearly against their moral conscience.
- In an era of rising health costs, providing this coverage would do nothing but raise the total cost of insurance for all. More and more legitimate coverage is being eliminated or scaled down to cut costs; to provide for an elective service that provides no curative or treatment benefit would be adding to that cost.

I urge you to reflect on these points as you consider this bill. Thank you for the opportunity to speak on this issue.

Respectfully submitted,

Judy Smith

Judy Smith, State Director
Concerned Women for America of Kansas

CONCERNED WOMEN FOR AMERICA
OF KANSAS

P.O. Box 11233 • Shawnee Mission, KS 66207 • Phone/Fax (913) 491-1380 • Email: judylsmith@compuserve.com

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LEGISLATIVE TESTIMONY

the Kansas Chamber of Commerce and Industry
The Unified Voice of Business

835 SW Topeka Blvd. • Topeka, KS 66612-1671 • 785-357-6321 • Fax: 785-357-4732 • E-mail: kcci@kansaschamber.org • www.kansaschamber.org

HB 2777

February 10, 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 2777.

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.

KCCI's opposition to the legislation before you is not based on the particular requirements that will be imposed on health insurance, but on the Kansas Chamber's longstanding concern regarding health insurance mandates. As this Committee certainly understands, if passing HB 2777 negatively impacts the cost of insurance, it will not be insurance companies who will pay these higher costs.

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d, the cost will be passed along to all Kansans who receive their insurance through policie governed by state law.

Those affected by state insurance mandates are Kansans insured in small groups and individual policies. These are also the people who have the hardest time finding affordable insurance. 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 also challenges mandate proposals because they are an additional intrusion of government into the private insurance market. 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.

One final point. Last legislative session, a testing procedure utilizing the Kansas health insurance program was approved by the legislature regarding insurance mandate questions. If there is merit found in the mandate proposed in HB 2777, KCCI would urge that the testing mechanism be first employed, rather than imposing the mandate on the private sector, as would happen if the bill before you today is approved.

Thank you for considering the Kansas Chamber's concerns regarding HB 2777. I would be happy to answer any questions.

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RIGHT TO LIFE OF KANSAS, INC.

214 S.W. 6th St., Suite 208, Topeka, KS 66603-3719 - Phone: 913-233-8601

Testimony To The House Committee On Insurance: House Bill 2777

Thursday February 10, 2000

I would like to thank you Chairperson Tomlinson and members of the committee for the opportunity to testify against House Bill 2777.

Right To Life of Kansas, Inc. opposes this bill for various reasons. This bill would require insurance companies to cover all artificial birth control devices and chemicals approved by the FDA. This isn't only about contraception due to the fact that many of these so-called "contraceptives" that would be mandated by this legislation are abortifacient in nature. Up until now, insurance companies have not been forced to cover drugs they feel are immoral or not medically necessary, but if this bill passes, they will be forced to act against their moral beliefs.
Insurance companies who morally oppose abortion would not be helped by this legislation, pro-life premium payers who would be forced to pay for something they do not support would not be helped by this legislation, and most importantly, babies who are being killed as a result of this legislation would not be helped

Thank you for the opportunity to testify before you today and I would like to ask you to please carefully consider all aspects of this legislation.

Cleta Renyer
Legislative Director

AMERICAN LIFE LEAGUE, INC.

Affiliated with American Life League

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Deaths Associated with the Birth Control Pill in England 1994-1997
(Same types of Birth Control sold by Planned Parenthood)

ADR No	Product	Fatal Reaction	Age	Sex	Date Prescribe	Date of Death
302724	Mercilon	Pulmonary Embolism	37	F	11/14/91	01/04/94
305051	Marvelon	Pulmonary Embolism	40	F	N/A	03/17/94
309867	Femodene	Pulmonary Embolism	27	F	08/1993	07/14/94
312030	Femodene	Pulmonary Embolism	18	F	04/14/94	05/23/94
319995	Logynon	Pulmonary Embolism	26	F	03/31/94	03/08/95
320151	Femodene	Pulmonary Embolism	21	F	N/A	03/08/95
321663	Femodene	Pulmonary Embolism	16	F	N/A	01/29/95
322175	Femodene	Pulmonary Embolism	28	F	03/08/95	03/28/95
322177	Logynon	Pulmonary Embolism	17	F	07/23/93	05/03/94
322928	Norplant	Suicide	31	F	07/23/93	05/03/94
323454	Marvelon	Left ventricle failure	33	F	1992	06/05/95
324893	Femodene	Pulmonary Embolism	47	F	07/02/94	04/18/94
327135	Logynon	Pulmonary Embolism	21	F	11/1992	08/28/95
327761	Microgynon	Pulmonary Embolism	24	F	N/A	07/21/95
327821	Microgynon	Pulmonary Embolism	40	F	N/A	07/21/95
328109	Minulet	Subarachnoid haemorrhage	17	F	01/1995	09/16/95
329035	Femodene	Pulmonary Embolism	44	F	10/13/93	07/18/95
331085	Marvelon	Pulmonary Embolism	27	F	03/17/95	12/10/95
332855	Binovum	Pulmonary Embolism	19	F	N/A	01/28/96
337939	Microgynon	Pulmonary Embolism	30	F	12/30/96	01/26/96
340648	Micronor	Pulmonary Embolism	47	F	12/1995	03/04/96
341374	Cilest	Pulmonary Embolism	33	F	07/09/96	08/19/96
341787	Microgynon	Pulmonary Embolism	39	F	05/1996	05/28/96
B704704	Marvelon	Pulmonary Embolism	27	F	N/A	10/05/96
M901718	Marvelon	Pulmonary Embolism	34	F	08/18/94	01/08/95
N601958	Microgynon	Pulmonary Embolism	25	F	N/A	03/10/94
N603019	Marvelon	Pulmonary Embolism	22	F	12/1991	01/23/95
N603199	Mercilon	Pulmonary Embolism	50	F	N/A	03/08/95
W802581	Noriday	Sudden death unexplained	48	F	1989	04/09/95
W803199	Cilest	Pulmonary Embolism	22	F	N/A	08/04/95
346517	Norplant	Cervical ca in situ	N/A	F	04/22/94	01/20/97
347220	Loestrin	Pulmonary Embolism	28	F	07/01/96	12/22/96
348146	Minulet	Pulmonary Embolism	18	F	N/A	02/28/97
348863	Cilest	Pulmonary Embolism	34	F	N/A	02/04/97
350115	Microgynon	Pulmonary Embolism	38	F	10/19/95	04/01/97
350987	Microyynon	Pulmonary Embolism	22	F	10/26/95	09/24/96
355433	Marvelon	Pulmonary Embolism	23	F	12/05/91	01/24/95
355489	Microgynon	Multiple pulmonary emboli	29	F	N/A	06/16/97
356762	Marvelon	Multiple pulmonary emboli	33	F	09/24/96	01/03/97
357204	Loestrin	Pulmonary Embolism	43	F	07/1996	07/05/96
357278	Cilest	Multiple pulmonary emboli	23	F	05/1997	09/14/97
358100	Microgynon	Pulmonary embolism	21	F	02/1997	02/28/97
358221	Microgynon	Pulmonary Embolism	26	F	04/25/97	06/06/97
358488	Cilest	Pulmonary Embolism	23	F	04/07/97	09/07/97
B703057	Femodene	Cerebral infarc	42	F	09/06/93	08/15/94
B703810	Minulet	Pulmonary Embolism	20	F	07/17/95	11/10/95

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B703824	Minulet	Pulmonary Embolism	25	F	06/03/91	01/16/96
B704327	Microgynon	Pulmonary Embolism	25	F	11/27/95	12/24/95
B704328	Cilest	Pulmonary Embolism	32	F	12/20/95	12/25/95
B704328	Femodene	Pulmonary Embolism	32	F	1992	12/25/95

The preceding information in the first list are those cases directly related to Planned Parenthood. The third list (Birth Control Deaths) is not directly related to Planned Parenthood; however Planned Parenthood does sell some or all of these birth control products and of course, they advocate the use of dangerous birth control products across the board, including those recently approved, (PREVEN) which is a dosage four times greater than that of a regular birth control pill.

Let the length of this list and the fact that it is merely representative of a only a portion of the injuries and deaths directly related to the abortion and birth control industries be a reminder to all that many will not be celebrating "Healthy Women's Day" today.

HAPPY HEALTHY WOMEN'S DAY!!!!!!!!!!

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Judie Brown is president of American Life League, the nation's largest pro-life educational organization with more than 300,000 supporters. ALL / P.O. Box 1350 / Stafford, VA 22555 / 540-659-4171/ http://www.all.org.

TESTIMONY

H.B. 2777

HOUSE INSURANCE COMMITTEE – Room 519-S
Thursday, February 10, 2000, 3:30 p.m.

KANSAS CATHOLIC CONFERENCE
Beatrice E. Swoopes, Acting Executive Director

Chairman Tomlinson, committee members, I am Beatrice Swoopes, Acting Executive Director of the Kansas Catholic Conference, which represents the Roman Catholic Bishops of Kansas. Thank you for the opportunity to speak to the provisions of **H.B. 2777**, the parity in prescription insurance and contraceptive coverage act of 2000.

The Kansas Catholic Conference is opposed to this bill for several reasons, generally because it goes against our Church's teaching on contraception.

More particularly the State of Kansas presently allows insurance companies to provide coverage for contraception for the percentage of the public that desires it. Since these plans are available and clients are free to choose this coverage then the mandate is unnecessary to ensure "access" to such coverage. Also, to mandate coverage as seen in Sec. 3 (1) makes the cost of insurance increase for everyone.

Aside from this, and our specifically religious concerns we object to the language because "contraceptive coverage" is not defined. There is broad agreement that such drugs though approved as "contraceptive" by the FDA, often work by ensuring the destruction of an early human embryo. This raises broader moral concerns about early abortion. The effect of this policy is to force health plans to cover controversial abortifacients such as the new so-called "morning after" pill, which the FDA has approved as "emergency contraception" (EC) although it is used to destroy the

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Testimony of Barbara Holzmark, Kansas Public Affairs Chair
Greater Kansas City Section, National Council of Jewish Women
8504 Reinhardt Lane, Leawood, KS. 66206
(913)381-8222, Fx: (913)381-8224, E-Mail: bjbagels@aol.com

Representative Tomlinson and Members of the House Insurance Committee:

My name is Barbara Holzmark and I am the Kansas Public Affairs Chair for the=
=20
Greater Kansas City Section of the National Council of Jewish Women (NCJW).=20=
=20
We are nearly 1000 members strong in the metropolitan Kansas City area, 200=20
sections across the United States, and 90,000 members nationwide.

I write to you in favor of HB 2777.

The mission of NCJW, a volunteer organization inspired by Jewish values, is=20
to work through a program of research, education, advocacy and community=20
service to improve the quality of life for women, children and families and=20
strives to ensure individual rights and freedoms for all people. We do not=20
discriminate, all people deserve individual rights and freedoms!

One of our National priorities states that in order to accomplish our=20
mission, the NCJW will work for the advancement and the well-being and statu=
s=20
of women. Another priority is to ensure individual and civil rights. In=20
order to advance the well-being of women, we endorse and resolve to work for=
=20
"comprehensive, confidential, accessible family planning and reproductive=20
health services for all, regardless of age or ability to pay". Our priorit=
y=20
to ensure individual rights endorses us to work for "the protection of every=
=20
female=92s right to reproductive choice, including safe and legal abortion,=20=
and=20
the elimination of obstacles that limit reproductive freedom. While our=20
mission guides us to help improve the quality of life for women, children an=
d=20
families, our principles, though many, encourage respect of human rights and=
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dignity as they are fundamental beliefs and must be guaranteed to all=20
individuals.

In allowing contraceptive coverage for women, the state can be proud to say=20
that they respect women and families, they trust women and families and they=
=20
have provided an arena for the well-being of women. Yes, NCJW is Pro-Choice=
,=20
and wants safe and legal abortions available to all women, however, if=20
contraception were available through ones insurance plan, a woman would be=20
able to make that choice to protect her reproductive rights. Family plannin=
g=20
is very important to women, and many of them do not have the choice or=20
know-how to protect themselves. I urge you to vote favorably on HB 2777.

Thank you for allowing me to present this testimony to you.

Barbara Holzmark

=20

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: HB 2708 – Classifying OB/GYNs as primary care providers; access

DATE: February 10, 2000

Mr. Chairman and members of the Insurance Committee:

Thank you for the opportunity to discuss with you HB 2708, which allows obstetricians and gynecologists to be classified as primary care providers. If the OB/GYN chooses not to be a primary care provider, the health insurer shall permit an insured woman to receive an annual visit to an in-network OB/GYN for routine gynecological care without requiring the insured woman to first visit her primary care provider.

A recent survey completed in Northern California revealed that of the responses from 5,164 women (age 35 years, plus) over half--56 percent--had seen a gynecologist for the last pelvic examination, only 18 percent had seen their primary care physician for the exam. In that same study, 60 percent of the women stated they preferred a gynecologist for basic gynecology care. Only 13 percent preferred their own PCP.

Yet, many women cannot easily go to an OB/GYN. Women who prefer to go to their OB/GYN, instead of their PCP for their annual pelvic examination, first have to go to their PCP, which means an extra appointment and more time. Why should women be forced to see two doctors when the only need one doctor.

The legislative movement for women to obtain direct access to OB/GYNs began in 1994 when Maryland became the first state to classify an OB/GYN as a primary care physician (PCP), and allow direct access. Since that time 39 other states have enacted OB/GYN direct access laws. While the laws vary, each gives women direct access to

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OB/GYNs or other women's health providers for their annual visit. Some of the laws require plans to permit qualified OB/GYNs as primary care physicians; others allow unlimited access, or access for routine gynecological and pregnancy service only, without a referral. I have attached a list of those states passing laws or regulations allowing women direct access to OB/GYNs.

Mr. Chairman and members of the committee, there really isn't a good reason why some women should be forced to see two doctors when they only need one. This is an issue that affects the lives of the female population of Kansas. Women want the option to see a specialist in women's health throughout their lifetime. It's time to put a law on the books to insure Kansas women have access to the best health care available to them. This proposed legislation affords the opportunity to promote primary and preventive health care. I respectfully urge you to favorably pass HB 2708 out of committee.

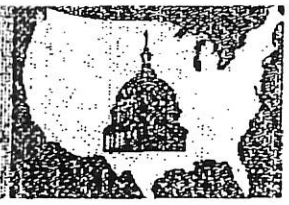
STATE INSURANCE MANDATES FOR OB-GYN PRIMARY CARE/DIRECT ACCESS, 1994-2000

[Current as of February 2000]

STATE LAWS/RULES/REGS (1994-1999) - #40	2000 ACTIONS
Laws: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin **Department of Health and/or Insurance Rule:** New Jersey, New Mexico, Vermont, West Virginia **Implementing/Enforcement Regs:** Colorado, New York, Pennsylvania, Texas, Washington	**Pending Bills:** Hawaii, Kansas, Kentucky, Missouri, New Jersey

GENERAL DESCRIPTION AND INTENT OF LAWS/REGS (These are broad categorizations. For actual language, see individual laws, rules, or regulations.)	STATE
PRIMARY CARE *Insurers* must permit eligible ob-gyns to contract as primary care physicians thereby allowing female enrollees to select such an ob-gyn in their insurance plan as their primary care physician. Women do not have direct access unless they select an ob-gyn as their primary care physician.	CA, FL, IN, NE, NJ, UT, WV
DIRECT ACCESS *Insurers* must permit female enrollees to self-refer (i.e., direct access) to a participating ob-gyn in their insurance plan for certain specified obstetric and gynecologic services without a gatekeeper's preapproval or preauthorization. Insurers are not required to permit ob-gyns to contract as primary care physicians.	AR, CA, CO, CT, FL, GA, IL, LA, MD, MI, MN, MO, NV, NH, NY, NC, OH, PA, RI, SC, TN, TX, UT, VA, VT, WA, WV, WI
BOTH PRIMARY CARE AND DIRECT ACCESS *Insurers* must (1) permit eligible ob-gyns to contract as primary care physicians (PCPs) thereby allowing female enrollees to select such an ob-gyn in their insurance plan as their PCP; and also (2) permit female enrollees to self-refer for their obstetric and gynecologic care. This means that women have maximum choice: They can either select an eligible ob-gyn as their PCP or, if they select a non-ob/gyn as their PCP, they can still self-refer to an ob-gyn within their plan without having to go thru a gatekeeper (although services typically are more restricted with the self-referral option). This also means that ob-gyns have maximum choice: They will not lose patient access if they choose not to contract as PCPs because women are permitted to self-refer for their obstetric and gynecologic care.	AL, DE, DC, ID, ME, MS, MT, NM, OR but see also CA, FL, UT and WV above; CA, FL and UT have passed 2 distinct laws; WV has passed a law and a rule
STATE INSURER OPTION *Insurers* have the option under the law of permitting eligible ob-gyns to contract as primary care physicians. This means that ob-gyns may contract as primary care physicians only at the option of individual insurers; and women may select a participating ob-gyn as their primary care physician only at the option of their insurer.	CT, LA*, MD * insurer option applies to HMOs only

The American College of Obstetricians and Gynecologists • Department of State Legislative & Regulatory Activities
409 12th St., S.W., Washington, DC 20024-2188 • (202) 863-2392 • FAX (202) 863-0739



Bill Summary: HB 2708

SYNOPSIS: an act concerning health insurance; relating to the patient protection act; classifying obstetricians and gynecologists as primary care providers.

SECTION 1:

a. any health insurer shall classify an obstetrician or a gynecologist as a primary care provider.

b. any obstetrician or gynecologist chooses not to be a primary care provider, the health insurer shall permit a woman insured to receive an annual visit to an in-network obstetrician or gynecologist for routine gynecological care from an in-network obstetrician or gynecologist without requiring such woman to first visit a primary care provider, provided that:

1. the care is medically necessary, including, but not limited to care that is routine

2. following each visit for gynecological care, the obstetrician or gynecologists communicates with such woman's primary care provider concerning any diagnosis or treatment rendered; and

3. the obstetrician or gynecologist confers with the primary care provider before performing any diagnostic procedure that is not routine gynecological care rendered care during an annual visit.

SECTION 2: this act shall be part and supplemental to the patient protection act

AARP *in Kansas*

February 10, 2000

Good afternoon Representative Tomlinson and Members of the House Committee on Insurance. My name is Sharlee Mason. I am a volunteer member of the AARP State Legislative Committee. We represent the views of the more than 340,000 AARP members in the state of Kansas. Thank you for this opportunity to speak in *support* of *House Bill 2708* and *House Bill 2735*.

Managed care has become the dominant delivery system in the United States. A major legislative trend in the statehouses in the past 5 years has been to give women who are enrolled in managed care plans direct access to OB/GYN services by either not requiring a woman to first get a referral from her primary care provider or by allowing a woman to designate an OB/GYN as her primary care physician.

The movement to provide women enrolled in managed care plans with direct access began in l994 in Maryland. Since that time, an additional 37 states (AL, AR, CA, CO, CT , DE,FL, GA, ID, IL, IN, LA, ME, MN, MS, MO, MT, NV, NB, NH, NJ, NM, NY, NC, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI,WV-and the District of Columbia) provide women the option of designating an OB/GYN as their primary care provider or provide direct access to OB/GYN services.

According to the College of Obstetricians and Gynecologists, a significant number of women view their OB/GYN as their primary or only physician. For many women, an OB/GYN is often the only physician they see regularly during their reproductive years. According to a l993 Gallop poll, women are more likely to have a physical examination within the last two years from an OB/GYN than any other type of doctor (72% vs 57%) and the majority of these women consider their OB/GYN to be their primary care physician (54%).

We believe

- women should have direct access to obstetricians/gynecologists for routine gynecological care
- women should be allowed to designate these physicians as their primary care providers

Kansas is to be commended for proposing this type of consumer protection that will increase a woman's access to needed services. We ask that you pass HBs 2708 and 2735. Thank you again for this opportunity to express our views. I stand ready to answer any questions you may have.

Sharlee Mason 785/582-5890

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AARP Southwest Region Office ● 8144 Walnut Hill Lane, Suite 700-LB39 ● Dallas, TX 75231
214/265-4060 ● Fax 214/265-4061 ● www.aarp.org

KANSAS MEDICAL SOCIETY

February 10, 2000

To: House Insurance Committee

From: Jerry Slaughter
Executive Director

Subject: HB 2708 and HB 2735; concerning OBGYN services
HB 2709; concerning pediatricians

The Kansas Medical Society appreciates the opportunity to appear today on these three bills which deal with obstetrical and pediatric services. Because all three are related, this statement contains our comments on each.

HB 2709; classifying pediatricians as primary care providers. KMS supports this bill, which would require health plans to classify pediatricians as primary care providers in their networks. This is obviously consistent with what is happening in actual practice, as pediatricians do serve as the medical and primary care physician for children all across this state. We believe most plans do this already, but making it clear in the law is a good step. The committee may want to consider adding language to define what a pediatrician is, and we have included a definition as follows: "pediatrician means a physician, as defined in this act, who specializes in pediatrics."

HB 2708 and HB 2735; classifying obstetricians as primary care providers. KMS believes the intent of these bills can be achieved by providing that health plans be required to allow female insureds to access OBGYNs without a referral from a primary care physician. We support that requirement, and believe that many plans do so already. We do not believe that many OBGYNs will want to serve as PCPs and provide the full range of services which would be required in that capacity. However, we do support direct access to OBGYNs, and HB 2735 addresses that point. As we suggested above, if it helps clarify the bill, the committee may want to add the following definition: "obstetrician or gynecologist means a physician, as defined in this act, who specializes in obstetrics and/or gynecology."

Thank you for considering our comments.

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Kansas Academy of Family Physicians

889 N. Maize Rd, Suite 110 • Wichita, KS 67212 • 316-721-9005
1-800-658-1749 • Fax 316-721-9044 • kafp@southwind.net • http://www2.southwind.net/~kafp/

February 10, 2000

TO: House Insurance Committee
RE: Designation of OB/GYNs and Pediatricians as Primary Care Physicians

Chairman Rep. Tomlinson, Vice-chair Rep. Boston, members of the committee, guests and friends:

My name is Keith Wright. I am a family physician in Manhattan, and I'm appearing this morning representing the Kansas Academy of Family Physicians, which has over 770 members across the state. I serve as president of the KAFP this year. I am writing to express our members' views on House Bills 2708, 2709 and 2735.

In both 2708 and 2709, specialty groups of physicians are designated as primary care providers. In 2708, it is obstetricians and gynecologists. In 2709, it's pediatricians. To understand the bills, we must understand what primary care is. I want to discuss that definition with you today, and then mention some concerns in the light of that definition that are raised by HB 2708.

Here is the definition and discussion of primary care:

Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, gender, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician, utilizing other health professionals, consultation and/or referral as appropriate.

A primary care practice serves as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services. Primary care practices provide patients with ready access to their own personal physician, or to an established back-up physician when the primary physician is not available.

A primary care physician is a generalist physician who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's care. Such a physician must be specifically trained to provide primary care services.

-- Definition from the AAFP Compendium on Selected Health Issues.

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1-800-658-1749 • Fax 316-721-9044 • kafp@southwind.net • http://www2.southwind.net/~kafp/

As you can see from this extensive definition, simply designating a specialty of physicians as primary care physicians by law does not mean that they necessarily fulfill the role that primary care physicians should play in health care. In short, that's our concern. Women's health care involves looking after their total well being. For instance, the number one cause of death in women is heart disease. Primary care physicians need to be prepared to deal with any type of health issues, or make appropriate referral to other specialists.

With these concerns and issues in mind, we oppose HB 2708 in that it designates an OB/ GYN as a primary care provider. If you want to allow women an annual visit to an obstetrician/ gynecologist for routine gynecological care without first visiting a primary care provider, we urge you to do so without designating them as primary care physicians. This can be accomplished through the language contained in HB 2735 without designating every obstetrician/ gynecologist as a primary care provider.

In regard to HB 2709, we do not have the same objections since pediatricians are trained in the breadth of primary care for children. Thus, we do not oppose HB 2709.

I'd be happy to answer your questions if you have any. Thank you for your consideration.

Sincerely,

Keith A. Wright MD

Keith Wright, MD
President

10-12

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. 2735

DATE: February 10, 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. 2735. 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. 2735.

First, we are unaware of any obstetricians or gynecologists who are requesting to be primary care physicians. By their very nature, i.e., specialists, these doctors do not wish to have the primary care physician responsibilities. Next, the bill mandates at least two visits with an in-network obstetrician or gynecologist without requiring first a visit to a primary care provider. The bill goes on to detail what is necessary in order to take advantage of this mandate. One of the items is that the care is medically necessary, including care that is routine. Without

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One AmVestors Place
555 Kansas Avenue, Suite 301
Topeka, KS 66603
Telephone: (785) 233-1446
Telecopy: (785) 233-1939
wsneed@pwvs.com

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further definition, one could argue that the two phrases are in conflict. Finally, if the intent of the bill is simply to require a minimum of two visits to an obstetrician or gynecologist, then we would urge the Committee to simply say that if the bill is going to be considered. However, this mandate will have a direct cause, and as such, effect, on premiums, as it will allow visits with the specialist without regard to the gatekeeping provisions found in most managed care situations. This is further complicated by the fact that the bill uses the term "health insurer" and does not further define that phrase. Thus, it appears that the bill would affect not only managed care programs, but indemnity type health insurance as well.

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. 2735. 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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18-2

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

Michael A. Morrisey, Ph.D.
Lister Hill Center for Health Policy
University of Alabama-Birmingham

555 13th Street, NW • Suite 600 East • Washington, DC 20004-1109 • 202-824-1600 • http://www.hiaa.org

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.

- 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.

CONTENTS

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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.

18-8

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.

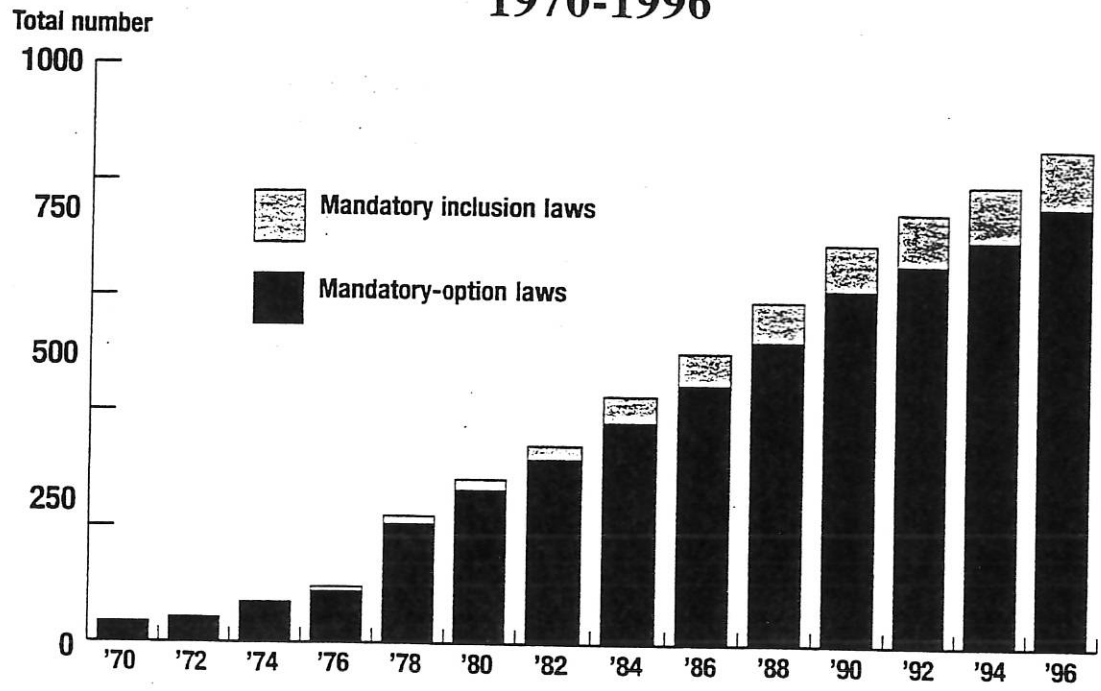
In the late 1980s and early 1990s, states began to legislate newer forms of insurance mandates, attempting to improve the small-group market by specifying particular service obligations within coverages, and delineating the nature of managed care networks.

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.

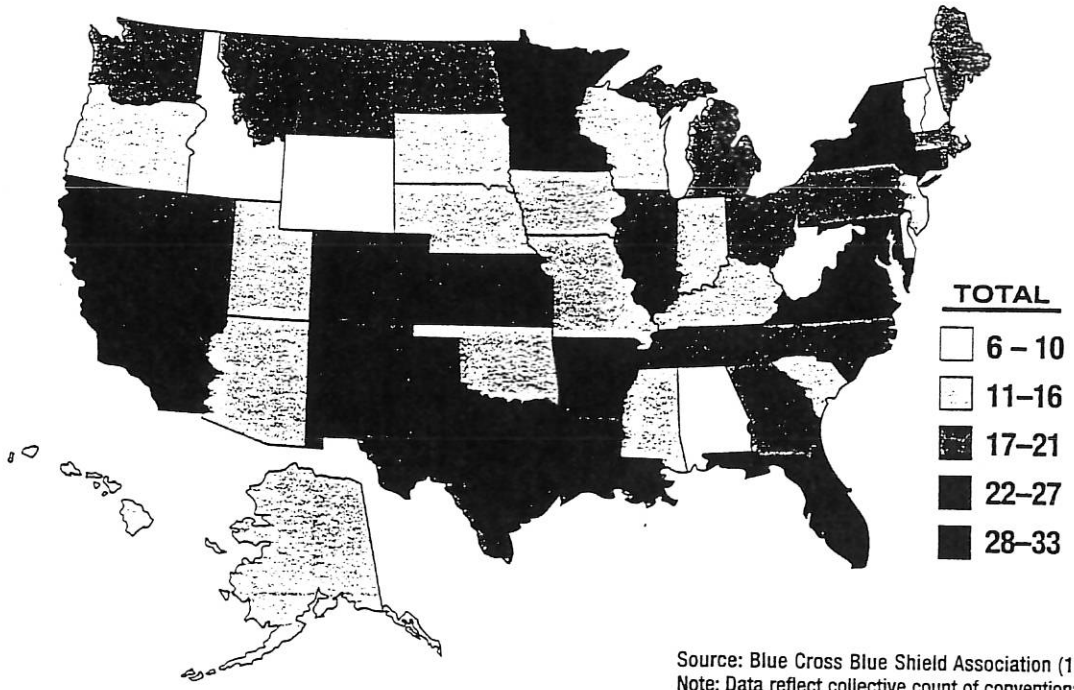
Growth in States' Conventional Mandates, 1970-1996



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

18-10

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

18-1

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.

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

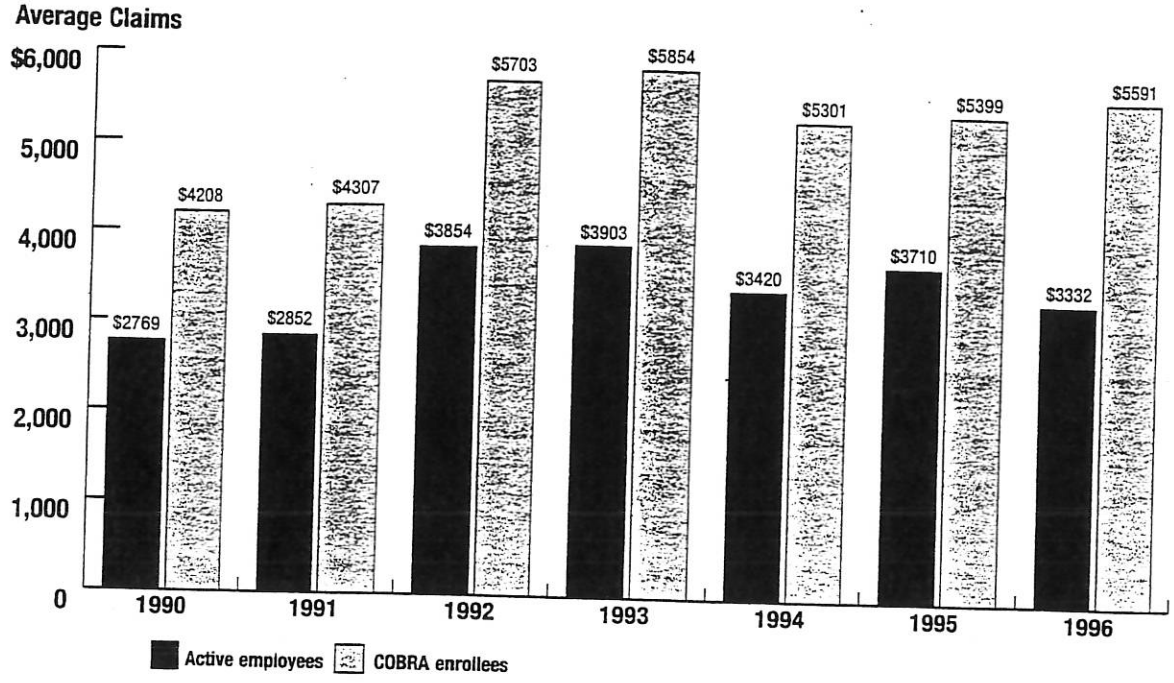

FIGURE 3

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].

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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Testimony of Douglas Iliff, MD
before the House Insurance Committee regarding *HB 2708* and *2735*
February 10, 2000

Conclusions

1. When Commissioner Sibelius says that the present system is not cost effective, she is dead wrong. In the first place, no woman wastes a visit at my office before she goes to the specialist for her pap smear, as the commissioner asserts in her Sunday column. Second, as I have already demonstrated, if that woman goes elsewhere for routine GYN care, she will often make an unnecessary visit with me to manage her other problems.

2. I am not trying to save managed care. I don't even like managed care. Managed care saved medicine as we know it-- that is, medicine relatively free of political manipulation-- by slamming the door on double-digit inflation in medical care in the early 1990s. Since then it has been under constant political attack, because it saves money by restraining the ability of Americans to see whatever doctor they want to see whenever they want to-- and, to be truthful, occasionally by denying or delaying needed care-- but, also to be truthful, far less often than in Canada, Great Britain, Germany, or the many other developed nations where the benevolent hand of government controls the purse strings. As always, "Compared to what?" is a useful question. Insurance companies can't control costs except by the most ham-handed means; we've tried using doctors to control costs, and the result is that a wedge of suspicion is driven into the doctor-patient relationship. Ultimately, we need to give **patients** their own pool of pre-tax dollars to manage themselves. No patient is going to authorize payment for bilateral arm surgery out of their own money if only one side was done.

3. As a point of clarification, when the Committee on Insurance and Rep. Stone use the term "care that is routine," they mean common gynecological outpatient services such as pap smears, breast checks, birth control discussions and prescriptions, vaginitis, STDs, and menopausal management. They are NOT referring to obstetrical care, which insurance companies have *never* subjected to "gatekeeper" approval, or gynecologic surgery, which has *always* been subjected to gatekeeper referral.

4. In Section 1 of HB 2708, insurers are commanded by legislative fiat to treat OB/GYNs as primary care providers. The medical profession considers primary care providers to be physicians capable of evaluating every organ system of the human body with regard to the most common presenting problems. That is, an internist or family physician may appropriately be asked about skin rashes, pneumonia, high blood pressure, diabetes, elevated cholesterol, sore ears, frequent nighttime urination, obesity, or-- an abnormal pap smear. OB/GYNs are valuable members of the medical team, but they are no more primary care physicians than other surgeons, gastroenterologists, neurologists, radiologists, or pathologists. Hippocrates once famously commented that "Life is short, and the Art is long"-- too long, in fact, for OB/GYNs to be good at what they do, and also good at what I do.

HSE Ins. Comm
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CAPITOL AREA
MONTHLY PRIMARY CARE PHYSICIAN
MANAGED CARE INCENTIVE REPORT
AS OF 12/31/97

PROVIDER NAME	ILIFF	R	COMMON PAY NO.	021120
PROVIDER ADDR	1119 GAGE BLVD		PROVIDER NO.	021120
	TOPEKA	KS	PROVIDER TAX ID.	481025301
			PROGRAM AREA	CAPITOL AREA

I. SETTLEMENT DATE 03/31/98

II. PCP RANKING/INCENTIVE PAYMENT

YOUR AVERAGE COST PER MEMBER PER MONTH IS 77.01

PERCENTAGE	PCP PEER RANKING	PERCENT RANKING	PER MEMBER PER MONTH INCENTIVE	PROJ. MEMBER MONTHS	PROJECTED INCENTIVE PAYMENT
1 - 20%		TOP 20%	1.25		
21 - 50%		NEXT 30%	.84		
51 - 70%	63.00%	NEXT 20%	.50	6,857	$ 3,428.50
71 - 100%		BOTTOM 30%	.00		

YOUR PROJECTED INCENTIVE IS $ 3,428.50 (INCENTIVE X PROJECTED MEMBER MONTHS)

III. CLAIMS INCURRED FOR 12 MONTHS ENDING 12/31/97 AS PAID THROUGH 12/31/97

	BLUE SELECT	HMO	TOTAL
PCP SERVICES	186,266.03	.00	186,266.03
REFERRED SERVICES	490,122.70	.00	490,122.70
OTHER SERVICES	368,273.21	.00	368,273.21
SELF REFERRAL SERVICES	20,514.97		20,514.97
HMS		56.00	56.00
TOTAL ALLOWED CHARGES	1,065,176.91	56.00	1,065,232.91
MEMBER MONTHS	13,817	16	13,833

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19-2

Kansas Association of Health Plans

Testimony before the
House Insurance Committee
The Honorable Robert Tomlinson, Chairman
Hearings on HB 2735
February 10, 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 2735. This bill mandates that a health insurer allow a woman to visit an in-network obstetrician or gynecologist for routine gynecological care, twice a year without a referral.

HMO's currently allow a woman to visit an ob-gyn for routine gynecological care once a year without a referral. Again, this routine visit is a covered benefit not because the government has demanded that we allow the visit, 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 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 to determine its cost impact. I will be happy to try to answer any questions the Committee may have.

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20-1

Kansas Association of Health Plans

Testimony before the
House Insurance Committee
The Honorable Robert Tomlinson, Chairman
Hearings on HB 2708
February 10, 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 2708. This bill mandates that a health insurer allow an obstetrician or gynecologist to choose to be a primary care physician. If the obstetrician or gynecologist chooses not to be a primary care physician then the plan must allow a woman to visit an in-network obstetrician or gynecologist for routine gynecological care, once a year without a referral.

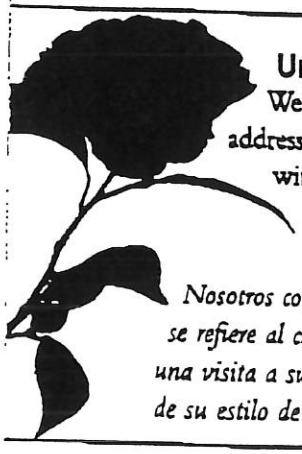
Once again, I apologize for my repetitiveness, of the HMO's responding to my survey, all currently allow a woman to visit an ob-gyn for routine gynecological care once a year without a referral. Again, this routine visit is a covered benefit not because the government has demanded that we allow the visit, 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 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.

Postcard #1

HUMANA Health

Improving the health of our members.



Understanding your needs.

We understand that women have unique needs. The following information addresses preventive care and health issues relating only to women. Schedule a visit with your doctor and ask how you can make preventive care a part of your healthy lifestyle.

Entendiendo sus necesidades.

Nosotros comprendemos que las mujeres tienen necesidades únicas. La siguiente información se refiere al cuidado preventivo y asuntos de salud que atañen sólo a las mujeres. Programe una visita a su médico y pregúntele cómo puede hacer del cuidado preventivo una parte integral de su estilo de vida saludable.

Regular PAP smears are key to good health.

Having a PAP smear is one of the most successful ways to detect conditions affecting women only. Your doctor can identify certain problems even before you have symptoms - and offer the appropriate treatment. Ask your doctor if you are due for a PAP smear.

Un cuidado regular de los pies le puede manten.

Una prueba de Papanicolau es una de las más exitosas maneras de detectar condiciones médicas que afectan a las mujeres solamente. Su médico puede identificar ciertos problemas - y ofrecerle el tratamiento apropiado. Pregúntele a su médico si ya es hora de que le hagan una prueba de Papanicolau.

A mammogram could save your life.

A yearly mammogram is very important to your health. In fact, this simple test can reveal breast cancer at the earliest stages, when it is most successfully treated.

Una mamografía puede salvarle la vida.

Una mamografía anual es muy importante para su salud. De hecho, esta sencilla prueba puede detectar el cáncer de seno en sus primeras etapas, cuando se le puede tratar con mayor éxito.

Call your doctor today and schedule your preventive care exams.

Llame a su médico hoy mismo y haga citas para sus exámenes de cuidado preventivo.

Simple changes bring great rewards.

A few changes in your daily routine can improve your quality of life. When you eat a nutritious diet and exercise regularly, you can reduce your risk for many major diseases. Exercise, such as walking or dancing, may also lower your risk for developing osteoporosis. Other ways to prevent osteoporosis are to take calcium supplements and avoid smoking. Your doctor may also suggest hormone replacement therapy. Ask your doctor to help you create a diet and exercise program that's best suited to your total health needs.

Cambios sencillos le pueden recompensar en grande.

Unos cuantos cambios en su rutina diaria pueden mejorar su calidad de vida. Cuando usted lleva una dieta nutritiva y hace ejercicio con regularidad, puede reducir su riesgo de contraer muchas enfermedades graves. El ejercicio como caminar o bailar también puede reducir su riesgo de desarrollar osteoporosis. Otras maneras de prevenir la osteoporosis son tomar suplementos de calcio y evitar fumar. Su médico también podría sugerirle terapia de reemplazo hormonal. Pídale a su médico que le ayude a diseñar el programa de dieta y ejercicio más apropiado para todas sus necesidades de salud.

HUMANA.

Preventive Service Areas Important to Women's Well Care Team

)uality Management has audited the Plan's performance in the important ventive service areas of pap smears and mmography. In 1994 compliance was at ercent for pap smears and 73 percent for mmograms based on HEDIS criteria for and periodicity. A TQM team was imple- ted to improve the number of women iving these screening examinations. A inder program began in June of this year.

ring her birthday month, each woman ntified as not having had these services ives two pieces of information:

a birthday card that is also a reminder to dule a wellness checkup

a pamphlet that contains instructional grams and explains the importance of nt self-breast exams.

followup measure of the June mailing icates 113 women, of the 2,175 who were led cards, scheduled a physical exam appointment. This measure combines both the staff model medical centers and network members who were surveyed by telephone. Subsequent measures indicated that on average 113 staff model women a month continue to schedule this examination. Additional measures are being pursued by the team.

First, another survey of those who have received the card is planned. The team will be seeking to identify any perceived barriers to obtaining these services and the effectiveness of the reminder.

Next, the team plans to evaluate whether or not services received after the card is sent can be identified in the Humana claims and encounter systems. We are pursuing having the individuals run back through the systems to identify services received since the initial search.

Another solution being considered is forwarding to each provider and/or medical center, on a monthly basis, a list of their patients who have been identified as not having had these services and who have been mailed a birthday card reminder. From there each office can pursue further interventions to assure their patients are receiving the covered preventive care.

Sending such a list to provider offices would afford providers the opportunity to identify faulty system data for the Plan. We already know the discrepancy in our level of compliance in these areas differs by about 38 percent when administrative data is compared to chart review.

The team meets the first and second Wednesday of each month and would welcome any suggestions or feedback from your perspective. You can contact either of the team leaders, Dr.Robert McCormack or Allene Broffel at the Administrative office, 816-941-8900. ▼

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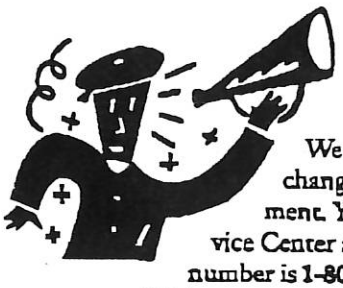
Summer 1997



New Number and Hours for Customer Service

We are pleased to announce a big change in our Customer Service department. You can now call our Customer Service Center at our new, centralized location. The number is **1-800-4-HUMANA (1-800-448-6262)**.

With our new Customer Service Center, we expand our hours and provide more staff to better serve your needs. We will also be able to solve problems faster, since the new service center is also responsible for processing your claims. Customer Service representatives will be able to enter corrections or additional information into your records. The new Customer Service hours are Monday through Friday, from 8 A.M. to 9 P.M., and Saturday, from 8 A.M. to 1 P.M.

For your convenience, we have provided you with two cards with the new Customer Service number and hours, and the mailing address for claims. The cards are on the insert between pages 16 and 17 of this issue of *Health Journal*. Simply cut the cards out and place one in your wallet and one near your telephone at home.

Our new Customer Service Center is just one of the ways that we are working to improve service to you. We will continue to work hard to provide improved health plan products and services so that we may continue to earn your support.

Your Well-Woman Benefits

If you are a female HMO member, you can now schedule your annual well-woman examination with either your primary care physician (PCP) or a participating Humana gynecologist. You do not need a referral to see a gynecologist for this exam, as long as he or she participates with Humana. Your gynecologist will report his or her findings and recommendation to your Humana PCP. The well-woman exam may include a Pap smear and a mammogram.

As part of your well-woman benefit, we also send you a birthday card to remind you to get your annual well-woman checkup. This special greeting is our way of reminding you of the importance of these screenings. You also receive an educational pamphlet on breast self-examination in the mail. Remember, most women should have a Pap test every three years and a mammogram every two years.

We hope that this expanded benefit will make it easier for you to schedule your well-woman examination. These examinations play an important part in detecting cancers and diseases early, when they are easiest to treat.

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Suite 200, 10450 Holmes
Kansas City, MO 64131-3471

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