Approved: March 6, 2001
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 20, 2001 in Room 527-S of the Capitol.

All members were present except:

Committee staff present: Bill Wolff, Legislative Research
Ken Wilke, Legislative Revisor

Conferees appearing before the committee: Representative Barbara Ballard
Representative Jo Ann Pottoroff
Representative Judy Morrison
Representative Mary Compton
Representative Judy Showalter
Ms. Kay Kent, Lawrence/Douglas County Health Department
Mr. Bill Sneed, Health Insurance Association of America
Mr. Brad Smoot, Blue Cross Blue Shield
Ms. Larry Ann Lower, Kansas Association Health Plans
Terry Leatherman, Kansas Chamber of Commerce & Industry

Others attending: See Attached Guest List

HB 2446: Insurance coverage for diagnosis and treatment of osteoporosis

The Chairman recognized Representative Barbara Ballard. Representative was before the committee to give Proponent Testimony on **HB 2446** - Insurance coverage for diagnosis and treatment of osteoporosis. A copy of Representative Ballard's testimony is (Attachment #1) attached hereto and incorporated into the Minutes by reference. She explained the reason for the bill is "to provide coverage to individuals with a condition or medical history for which bone mass measurement (bone density testing) is determined necessary for the individual's diagnosis and treatment of osteoporosis." She spoke on age, testing, and numbers of people with the problem. She spoke of the early need for detection. Representative Ballard then stood for questions. A question was asked by Chairman Tomlinson.

The conferees to come before the committee were Representatives Pottoroff, Morrison, Showalter, Compton. A copy of each written testimony is (Attachment #'s 2, 3, 4) attached hereto and incorporated into the Minutes by reference. Representative Morrison addressed the committee but did not have written testimony. Each Representative supported the testimony of Representative Ballard and spoke of people they each knew with the problem or their own personal experience with osteoporosis. A question was asked by Chairman Tomlinson and directed to Representative Pottoroff.

Ms. Kay Kent, Lawrence/Douglas County Health Department, was the next conferee before the committee. Ms. Kent also gave Proponent Testimony to the committee and a copy of the testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference. Ms. Kent related the same information on the disease. She informed the committee that many people do not know they have the disease until they fall, bump, bruise or break a bone. She urged the committee to support the bill for coverage to offset the high costs associated with the disease. There were no questions.

Ms. Linda DeCoursey, Kansas Insurance Department and Ms. Sally Finney, Kansas Public Health Association, Inc., both presented written testimony supporting the bill. A copy of each of the testimonies are (Attachment #'s 6, 7) attached hereto and incorporated into the Minutes by reference.

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

Mr. Bill Sneed, Health Insurance Association of America, came before the committee to present Opponent Testimony. A copy of the testimony is (Attachment #8) attached hereto and incorporated into the Minutes by reference. Mr. Sneed stated that his 255 plus members provide health insurance to approximately 110,000,000 Americans and they were unaware of any insurance contract that did not cover this type of testing if the physician deemed it "medically necessary." He stated that they would not cover it if someone just walked in off of the street to some physician or clinic and decided to have all of these tests run. The test had to be prescribed or ordered by your physician and would need to be "medically necessary." In Mr. Sneed's testimony is a study by Dr. Gail A. Jensen and Dr. Michael A. Morrisey on mandated benefit laws and employer-sponsored health insurance. Mr. Sneed and his clients feel this document shows that mandated coverages drive costs of insurance up and have the opposite effect on the marketplace. Mr. Sneed stood for questions.

Questions came to Mr. Sneed from Representatives Toelkes, Huff, Kirk, Sharp, O'Brien, Huy. Mr. Sneed reaffirmed that this coverage is already in place in the consumers policy. He again confirmed that "To the best of our knowledge, all insurance contracts under the purview of the Kansas Insurance Department require coverage for "medically necessary"testing and/or treatment."

The next conferee before the committee was Mr. Brad Smoot, Blue Cross, Blue Shield. Mr. Smoot also gave Opponent Testimony opposing the bill as it is written. A copy of this testimony is (Attachment #9) attached hereto and incorporated into the Minutes by reference. Included in Mr. Smoot's testimony was a balloon and a letter from Dr. Barbara Lukert, M.D., Director of the Hiatt Osteoporosis Center at the University of Kansas School of Medicine and Hospital. Mr. Smoot, Dr. Lukert and Mr. Smoot's clients do support the testing and treatment when it is medically indicated. Dr. Lukert set out indicators that assist in knowing if the testing is necessary, and supports the tests and treatment under "appropriate circumstances."

The balloon offered by Mr. Smoot strikes the "resolution style" language of Section 1 and adds language to "expand the scope of the bill to affect more people yet narrowing the mandate to those situations where good medical practice indicates a need for the testing or treatment." Mr. Smoot stood for questions. Questions were asked by Representatives Toelkes, O'Brien, Sharp and Huff. Again it was stated the coverage was there if it was "medically necessary" and that Blue Cross/ Blue Shield already followed this procedure.

Ms. Larry Ann Lower, Kansas Association of Health Plans, stood in Opposition of the bill and offered testimony to support her Opposition. A copy of the testimony is (Attachment #10) attached hereto and incorporated into the Minutes by reference. Ms. Lower supported the testimony previously offered by Mr. Sneed and Mr. Smoot and stated all thirteen HMO'S cover such expenses if such meets the points of testing. She also confirmed she was comfortable with Mr. Smoot's balloon.

Mr. Terry Leatherman, Kansas Chamber of Commerce and Industry was the final conferee to offer Opponent Testimony. A copy of the testimony is (Attachment #11) attached hereto and incorporated into the Minutes by reference. Mr. Leatherman offered no new testimony and confirmed he was comfortable with the offered balloon.

Public hearings on the bill were closed.

The next item of business was **HB 2422** - Suspended drivers licence; reinstatement hearing under certain circumstances. Representative Karen DeVita, offered Proponent Testimony to the committee and a copy of her testimony is (Attachment #12) attached hereto and incorporated into the Minutes by reference. Ms. Sheila Walker and Mr. Harry Tiffany, of the Kansas Motor Vehicle Department were here to answer questions but had no written testimony.

Representative DeVita explained the bill to the committee stating the bill inserting a mechanism for reinstatement of a suspended license when the uninsured motorist or owner has fulfilled the requirements of current law by insuring the vehicle and paying the damages, especially when the party cannot find the second party to gain a release of obligation . At the present there is no such mechanism in place, but there is a two year waiting period should you not be able to located the other party for their signature. She stated that this puts an undo burden on the violator who has done all that can be done to meet the current statute.

Representative DeVita concluded by saying that this amendment is a common sense remedy to create fair balance in the current law. She stood from questions and discussion from Chairman Tomlinson, Representatives Edmonds, Sharp, Grant, Huy, Boston and O'Brien, Mayans, Huff. The response included the statement that the bill sets in an administrative hearing.

Ms. Sheila Walker and Mr. Tiffany rebuffed some of the testimony stating that administrative hearings take place. Rep. DeVita cited cases where these meeting have not taken place or been available. Rep. DeVita also stated the amendment key word are "paid" not "entered into an agreement" as stated by the Department of Vehicles.

With no further testimony or discussion the hearing was closed.

The committee move on the work **HB 2306**, the Viatical bill. The committee was referred to the previous balloon. The motion was made by Representative Edmonds to adopt the sub bill and the was seconded by Representative Sharp. The motion was opposed by Representative Mayans. Representative Phelps–no laws governing viaticals. There was a motion to table the bill by Representative Boston and seconded by Representative Mayans. A hand vote was taken, 4voted yes and the rest opposed. Back on the motion with more discussion. Another hand vote taken and the motion carried 9-6, Representative voted no.

With this business completed the meeting was adjourned. The time was 6:10 p.m.

The next meeting will be held. March 1, 2001.

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

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: Feb 20, 2001

NAME	REPRESENTING
Kay Kent	Lawrence-Douglas Co. Health Dept
Kevin Barone	Hen/Weir. Child
Chuck Stones	KBA
Bill Sneed	HIAA
Jeremy Anderson	KS Insurance Dept
Linda DeCoursey	KS Insurance Dept
Mary Compton	
Larrie Ann Brown	KAHP
Brad Smoot	BCBS
Erik Sartorius	K.C. Regional Assoc. of Realtors
Julie Numrich	Federico Consulting
Todd Henderson	KS Pharm. Assoc.
Sheila Walker	KDOR-DMV
Harry Tiffany	KDOR-DMV
Rep. Barbara Ballard	KSL
Rep. Judy Morrison	KSL
Rep. Jo Ann Pottorff	KSL
Rep. Judy Showalter	KSL
Terry Leatherman	KCCI

Rep. Karen DeVito
Colleen Mullens.

HOUSE OF REPRESENTATIVES
STATE OF KANSAS

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TOPEKA

CAUCUS CHAIR

COMMITTEE ASSIGNMENTS
APPROPRIATIONS
SOCIAL SERVICES BUDGET COMMITTEE
JOINT COMMITTEE ON CORRECTIONS AND JUVENILE JUSTICE
LEGISLATIVE EDUCATIONAL PLANNING COMMITTEE

House Insurance Committee
Testimony on House Bill #2446
Presented by Representative Barbara W. Ballard
February 20, 2001

Thank you Chairperson Tomlinson and members of the Committee:

The purpose of HB 2446 is to provide insurance coverage to individuals with a condition or medical history for which bone mass measurement (bone density testing) is determined to be medically necessary for the individual's diagnosis and treatment of osteoporosis.

Osteoporosis affects 25 million Americans and each year results in 1.5 million fractures of the hip, spine, wrist and other bones, costing the nation at least $18 billion. One in two women and one in five men will suffer a fracture due to osteoporosis during their lifetime. According to John R. Lee, M.D., of Sebastapol, California, "Osteoporosis affects women more than it does men because women have less bone mass than men and begin to lose bone far earlier. Up to age thirty-five, men and women have equal bone stability. For women, the most rapid rate of bone loss occurs in the first five years after menopause, beginning around age forty-five, when body hormone supplies undergo a dramatic change. Men don't experience bone loss until after age seventy, but once they do contact osteoporosis, the condition can be severe."

Osteoporosis progresses silently, in most cases undiagnosed until a fracture occurs, and once a fracture occurs, the disease is already advanced, and the likelihood is high that another fracture will occur. Because osteoporosis progresses silently, and, currently has no cure, early diagnosis and treatment are key to reducing the prevalence and devastation of this disease. While there are currently available technologies for bone mass measurement, other technologies for measuring bone mass are under investigation and may become scientifically proven technologies in the future. Scientifically proven technologies for bone mass measurement and other services related to the diagnosis and treatment of osteoporosis can be used effectively to reduce the pain and financial burden that osteoporosis inflicts upon its victims. Medical experts agree that osteoporosis is preventable and treatable; however, once the disease progresses to the point of fracture its associated consequences often lead to disability, institutionalization and exact a heavy toll on the quality of life.

I will be happy to stand for questions.

House Comm on Ins.
Feb. 20, 2001
Attachment #1

STATE OF KANSAS

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TOPEKA

HOUSE OF
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TOURISM
CHAIRMAN: BUDGET COMMITTEE ON GENERAL
GOVERNMENT AND HUMAN RESOURCES
CHAIRMAN: ARTS & CULTURAL RESOURCES
CHAIRMAN: EDUCATION COMMITTEE
NCSL ASSEMBLY ON STATE ISSUES

TESTIMONY ON HB2446

Thank you Mr. Chairman for the opportunity to testify on HB2446.

Osteoporosis is a disorder in which bone mass is gradually lost in the skeleton, causing the bones to become progressively weaker. This disease threatens 28 million Americans each year, costing $38 million daily and rising. In the state of Kansas, 14% of the population has some degree of osteoporosis according to figures from 1996. One in two women and one in eight men over 50 will develop fractures as a result of this "silent" disease. Medical experts agree that osteoporosis is highly preventable and treatable. Detection is the first step to prevention. Bone mass measurements are taken in various sites of the body and can:

1. Detect osteoporosis before a fracture occurs.
2. Predict your chances of fracturing in the future.
3. Determine your rate of bone loss and/or monitor the effects of treatment if the test is conducted at intervals of a year or more.

By the time a fracture has occurred the bones are well beyond significant recovery. The goal of this piece of legislation is to help in diagnosis and thereby provide for the possibility of early treatment. The early treatment can be effective and will reduce overall medical costs, reduce pain to the afflicted, and contribute to the better quality of life for many older Americans.

I appreciate the opportunity to bring this issue to you.

House Comm on Ins
Feb 20, 2001
Attachment #2

Proponent of **HB 2446**
Rep. Mary Compton
State Capitol
Room 181-W
296-7684

February 20, 2001

Thank you, Mr. Chairman and Committee members for allowing me to come before you today.

My name is Mary Compton, I am a cosponsor of **HB 2446**, of which I am in support.

Osteoporosis is the silent disease that comes on slowly until a fall or fracture occurs, then treatment follows.

With early diagnosis, it is preventable or at least deterred with medication and calcium.

The bone density test is one way to check the progress of the disease or diagnose it before it begins.

I am one of those women who have had the test and caught it before any signs appeared. So with a higher dosage of calcium and exercise, I am trying to prevent the deterioration of bones.

It is a disease that attacks men as well as women, just not as frequently in men.

This bill would allow those individuals with a condition or medical history, which would benefit from the test to determine if treatment was necessary.

Thank you for your consideration of **HB 2446.**

I would stand for questions.

House Comm on Ins
Feb 20, 2001
Attachment #3

STATE OF KANSAS

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HOUSE OF
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HEALTH AND HUMAN SERVICES
RANKING MEMBER
AGRICULTURE
LOCAL GOVERNMENT
JOINT COMMITTEE ON HEALTH CARE
REFORM OVERSIGHT

Feb. 20, 2001

Chairman Bob Tomlinson
House Insurance Committee
State House
Topeka, Ks

Chairman Tomlinson, Thank you for allowing me to address your committee today on HB 2446 which addresses the need for insurance coverage for Osteoporosis testing.

This disease can sneak up on you and the first sign you have it is by falling and fracturing a hip or another bone. It can not be cured, but it can be slowed down by early detection, treatment and in some cases lifestyle changes.

The testing is most critical for those in the high risk areas, if they are diagnosed early and put on a treatment regimen the disease is controlled. Not cured, controlled.

A bone density test can detect Osteoporosis in the early stages. The cost of the test will be offset by treatment that will decrease the chances of expensive fractures and prolonged hospital stays in the future.

I would like to ask for your favorable consideration of the bill before you today.

Judy Showalter

House Comm on Ins
Feb 20, 2001
Attachment #4

Osteoporosis

- Bone Basics
- Risk Factors
- Prevention
- Calcium Food Sources

Risk Factors

The women with the highest risk factor for osteoporosis are usually white or asian and are small and thin. Other risk factors include:

- a family history of osteoporosis
- having an early or surgically induced (both ovaries removed) menopause before the age of 45
- being a post menopausal women
- being physically inactive
- smoking cigarettes or having an excessive alcohol intake
- a diet habit that is low in calcium sources (dairy products and some vegetables like broccolli)
- those individuals who must take high doses of cortisone-like drugs (therapies used in asthma, arthritis, or cancer) or taking high doses of thyroid medication

If you fall into any of the above risk catagories and you are in your forties, discuss your risks with your physician. Your physician may want a test called a bone-density measurement. This "baseline" measurement is useful later when it is compared to tests performed later in life to determine the density loss in the bone.

Calcium Food Sources

Dairy Sources:

Food	Amount	Calcium
Skim milk	1 cup	302 mg
Low fat cottage cheese	1 cup	155 mg
Plain fat yogart	8 oz.	415 mg

Non-Dairy Sources

Food	Amount	Calcium
Almonds	1 oz.	66 mg
Bread, whole wheat	1 slice	25 mg
Broccoli, raw	1 spear	72 mg
Broccoli, cooked	1/2 cup	68 mg
Carrot, raw	1 med.	27 mg
Collards, cooked	1/2 cup	168 mg
Dates, chopped	1/4 cup	26 mg
Dried beans, cooked	1/2 cup	26 mg

(lima, navy, kidney)		
Orange	1 med.	60 mg
Raisins	1/4 cup	22 mg
Peanut butter	2 tbsp.	18 mg
Salmon, pink	3 oz.	167 mg
(canned with bones)		
Sardines	3 oz.	372 mg
(Atlantic with bones)		
Spinach, cooked	1/2 cup	84 mg
Tortilla, corn	1 med.	80 mg
Turnip greens, cooked	1/2 cup	134 mg

Last Modified: 7/27/97,

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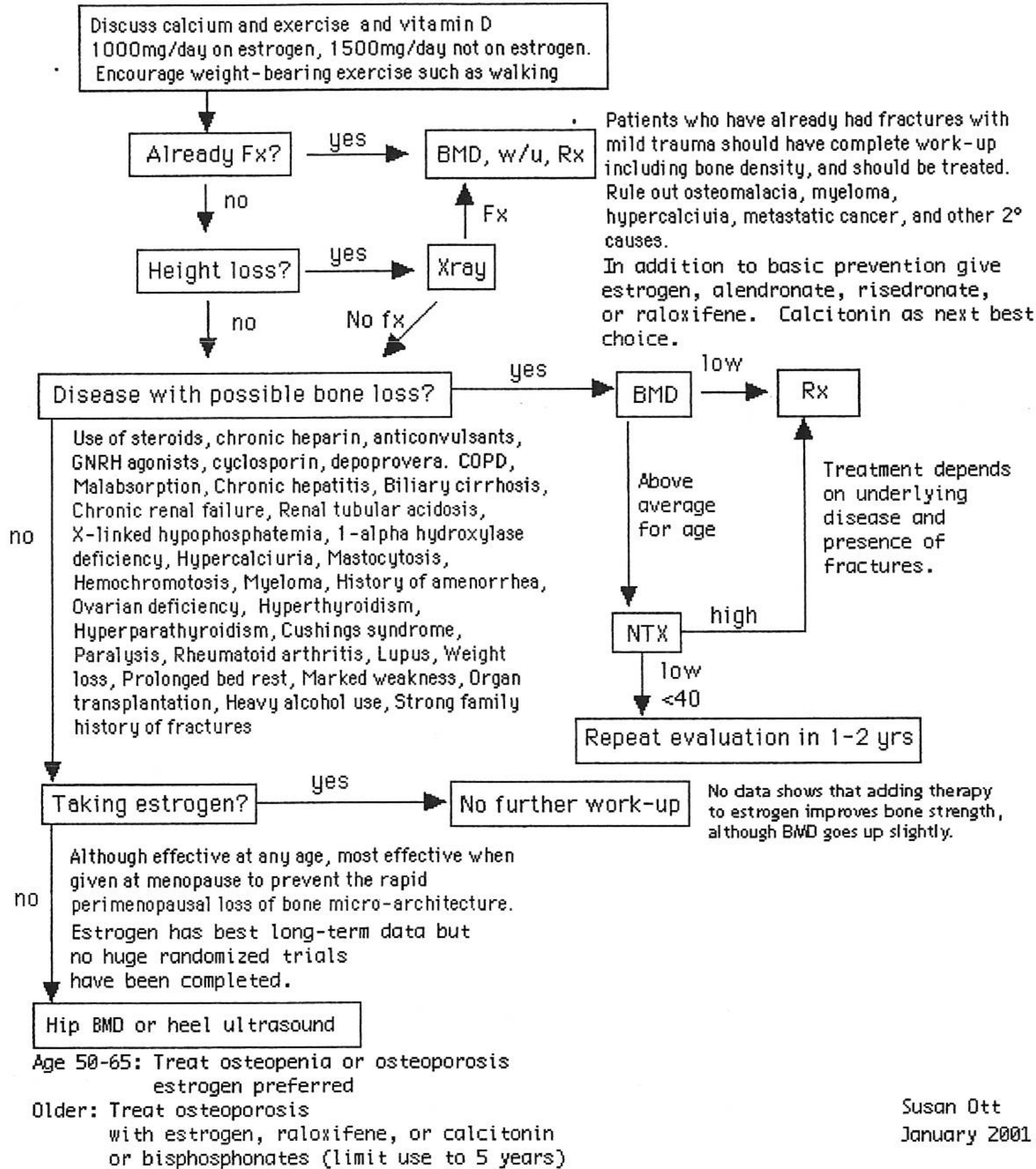

4-4

LAWRENCE-DOUGLAS COUNTY HEALTH DEPARTMENT
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Clinic: 785/843-0721 Fax: 785/843-2930

House Insurance Committee
February 20, 2001

Testimony presented by
W. Kay Kent, RN, MS
Administrator/Health Officer
Lawrence-Douglas County Health Department

Mr. Chairman and members of the Committee, thank you for the opportunity to appear before you today. I urge you to support House Bill No. 2446.

Osteoporosis is a major public health threat for 25 million Americans, 80 percent of whom are women. A woman's risk of hip fracture is equal to her combined risk of breast, uterine and ovarian cancer. The direct medical costs for osteoporosis is great, about $49 million each day.

Osteoporosis is often called the "silent disease" because bone loss occurs without symptoms. People may not know that they have osteoporosis until their bones become so weak that a sudden strain, bump, or fall causes a fracture or a vertebra to collapse.

Screening for osteoporosis is vital because early identification and intervention are key in helping to reduce the risk of a fracture and are cost effective. Without financial access to screening, diagnosis and treatment, we will not be able to curb the high medical costs associated with this disease and prevent the unnecessary human suffering that this disease causes.

I urge your passage of House Bill No. 2446.

House Comm on Ins
Feb 20, 2001
ATTACHMENT #5

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Linda De Coursey, Director of Government Affairs

RE: HB 2446 – Guarantees coverage of bone density testing for diagnosis and treatment of osteoporosis

DATE: February 20, 2001

Mr. Chairman and members of the committee:

Thank you for the opportunity to discuss with you HB 2446. The purpose of this bill is to provide insurance coverage to individuals with a condition or medical history for which bone mass measurement (bone density testing) is determined to be medically necessary for the individual's diagnosis and treatment of osteoporosis.

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

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

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

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House Comm on Ins
Feb 20, 2001
Attachment #6

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

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

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

In an analysis for this type of coverage last year (HB 2770) of whether or not health care insurers in Kansas provide the coverage provided for in HB 2770 (and now this year HB 2446) – coverage for bone density testing in the diagnosis and treatment of osteoporosis – some plans provide coverage, but only as a follow-up or treatment of an already diagnosed case. Others provide the coverage. I am asking for the passage of HB 2446 on behalf of Insurance Commissioner Sebelius to make sure all health insurance companies and plans, regulated in Chapter 40 of the statutes, provide this coverage. In the impact study required by K.S.A. 40-2248 and 40-2249 that was requested several years ago on this very same topic, companies or plans indicated that use of the bone density testing for diagnosis and treatment would not have a significant increase in their premiums, and in fact, the impact would be minimal. The diagnosis and treatment of osteoporosis, like the foresight of the legislature when it passed prostate cancer screening, is one of the cases where paying costs in prevention and early detection, reduce the costs of extenuating circumstances later.

Mr. Chairman, we respectfully ask your favorable consideration of HB 2446.

KANSAS PUBLIC HEALTH ASSOCIATION, INC.

KANSAS PUBLIC HEALTH ASSOCIATION, INC.
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To: House Committee on Insurance
From: Sally Finney, M.Ed., Executive Director
Re: HB 2446
Date: February 20, 2001

I am submitting this testimony on behalf of the Kansas Public Health Association, a non-profit membership organization established in 1920 and dedicated to promoting sound public health programs and policies to improve the health of the public in Kansas, to support House Bill 2446.

Osteoporosis threatens the health of 28 million Americans, 10 million of whom already suffer from the disease with another 18 million having reduced bone mass. One out of every two women and one in eight men over the age of 50 will have an osteoporosis-related fracture in their lifetime. **KPHA supports any measure that promotes early detection of bone loss because by increasing access to screening, we increase access to patient education.** Health professionals can teach patients identified with preventable risk factors for osteoporosis about reducing their risks.

While increased access to screening is important because of its role in preventing osteoporosis, **increased access to treatment is equally essential because it is now possible to stop or slow bone loss.** Early treatment reduces the risk of injury that can result in disability and loss of productivity.

I thank you for considering HIB 2446 and ask you to support this measure.

House Comm on Ins
Feb 20, 2001
Attachment # 7

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. 2446

DATE: February 20, 2001

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. 2446. 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. 2446.

My client is unaware of any insurance contract that would not cover bone mass measurement (bone density) testing and/or the diagnosis and treatment of osteoporosis. As noted on page 2, lines 14-15, such treatment would be "medically necessary." To the best of our knowledge, all insurance contracts under the purview of the Kansas Insurance Department require coverage for "medically necessary" testing and/or treatment.

House Comm on Ins.
Feb 20, 2001

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Telecopy: (785) 233-1939
wsneed@pwvs.com

Attachment #8

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

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

Based upon the foregoing, my client urges the Committee to reject H.B. 2446. Thank you very much for the opportunity to provide testimony, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W. Sneed

Attachments: 1

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HIAA

Health Insurance Association of America

Mandated Benefit Laws and Employer-Sponsored Health Insurance

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

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.

8-5

Introduction

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

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

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Current Scope of Group Insurance Regulation

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

Most Common State Mandates in 1996

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

TABLE 1

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

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

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State Mandates

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

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

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

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

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

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

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

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

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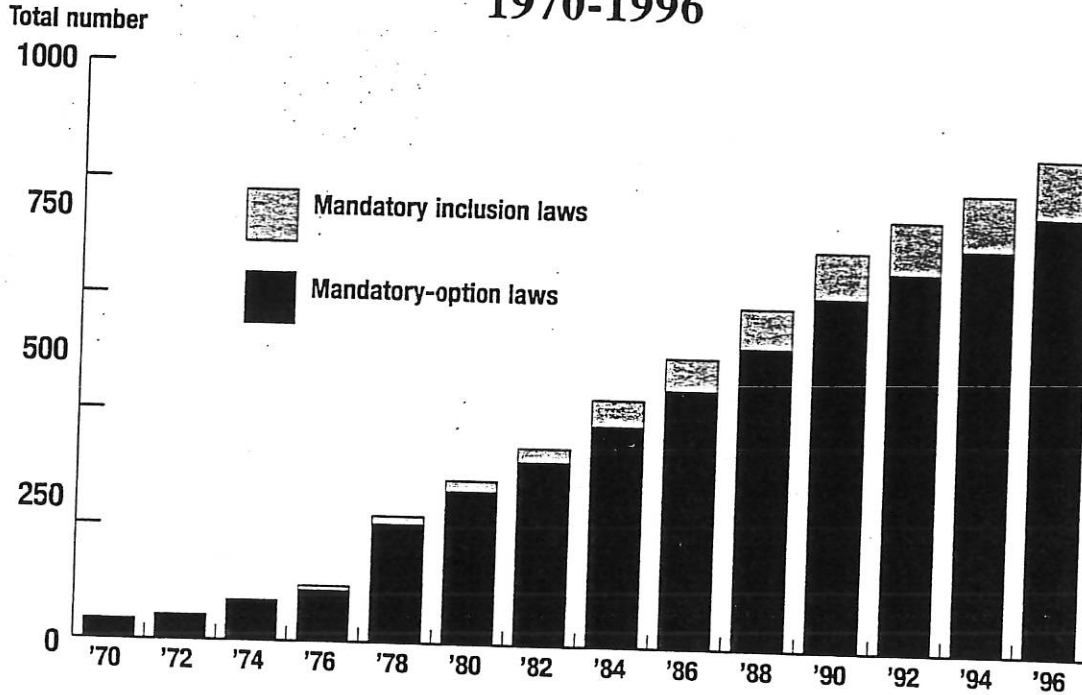
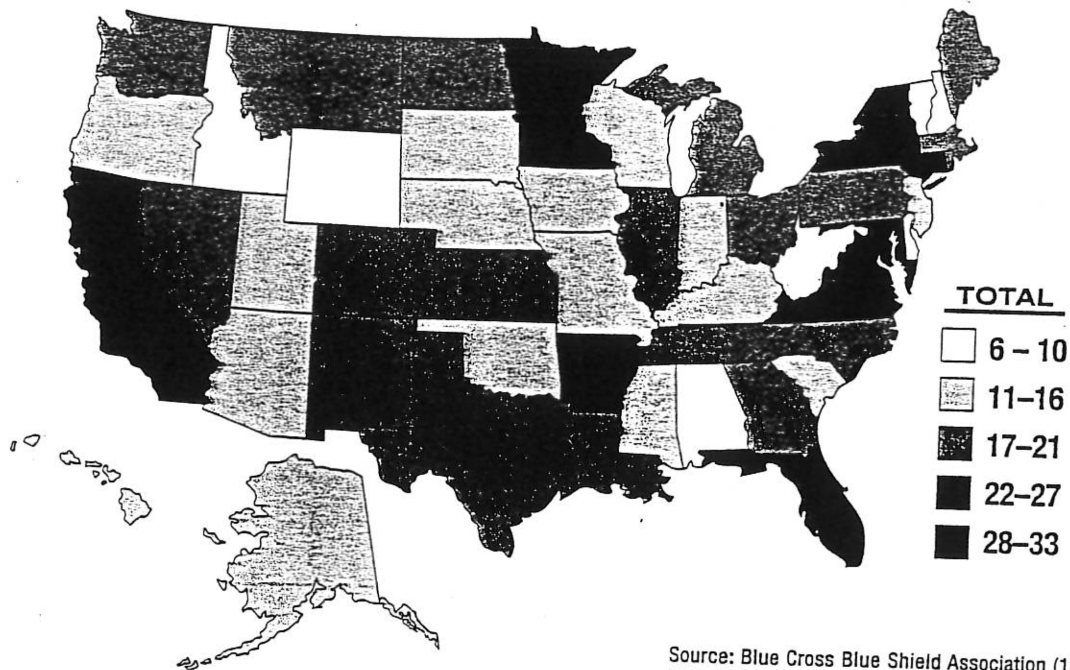
Growth in States' Conventional Mandates, 1970-1996



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

FIGURE 1

Conventional Mandated Benefits by State, 1996



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

FIGURE 2

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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

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

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

Federal Mandates

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

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

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

8/2

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.

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

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

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

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

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

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

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Evidence of the Effects of Mandates

Who Is Affected by Mandates?

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

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

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

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

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

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

8-16

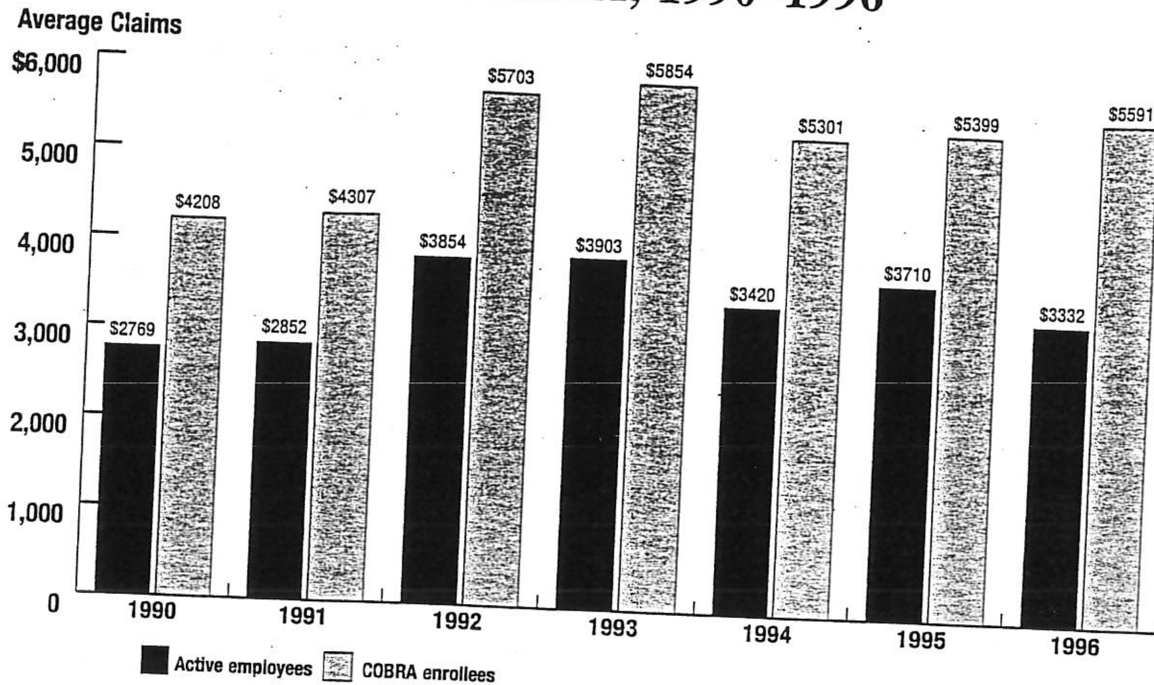

FIGURE 3

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].

8-18

ARE WAGES REDUCED AS A RESULT OF MANDATES?

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

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

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

DO SOME WORKERS LOSE COVERAGE AS A RESULT OF MANDATES?

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

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

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

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Have Mandates Encouraged Firms to Self-Insure?

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

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

Do Mandates Disproportionately Affect Small Firms?

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

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

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

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CONCLUSIONS

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

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

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

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

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

8-21

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STATEMENT of BRAD SMOOT
LEGISLATIVE COUNSEL
BLUE CROSS BLUE SHIELD OF KANSAS
and
BLUE CROSS BLUE SHIELD OF KANSAS CITY

THE HOUSE INSURANCE COMMITTEE
2001 HOUSE BILL 2446

February 20, 2001

Mr. Chairman and Members,

Blue Cross Blue Shield of Kansas is a non profit Topeka-based health insurer serving 103 Kansas counties and Blue Cross Blue Shield of Kansas City, also a non profit insurer, serves western Missouri and Johnson and Wyandotte Counties in Kansas. Together, they provide insurance coverage for 1 million of your fellow Kansans. We must respectfully oppose H 2446, as currently written.

As you know, BCBS plans generally oppose insurance mandates because they tend to increase the costs of health insurance to employers and families. Our opposition is somewhat tempered in those instances in which we already provide coverage and pay claims for the procedures that are the subject of the mandate. Such is the case regarding the testing for, and treatment of, osteoporosis. In other words, we pay for this now.

If the committee wishes to advance the bill, however, it should be amended to require reimbursement for bone density testing and osteoporosis treatment only in those instances in which it is medically indicated. Certainly, committee members would agree that all insureds do not need to be tested or treated and that testing or treatment which is unnecessary is a waste of health care resources.

Fortunately, there are some generally recognized indicators of when such testing and treatment should be used. Last year, Dr. Barbara Lukert, M.D., Director of the Hiatt Osteoporosis Center at the University of Kansas School of Medicine and Hospital, identified those indicators for this Committee in connection with H 2770. Letter attached. Dr. Lukert supports testing and treatment for both women and men under the appropriate circumstances.

Attached, are balloon amendments which strike the "resolution style" language of Section 1; add technical language frequently used in other mandates to cover group pools and the state employees plan (neither of which are covered by the bill as written), limit the mandate to physician services, allow for ordinary co-pays and deductibles and clarify that the testing and treatment are to be covered only when medically indicated for a given individual. These amendments expand the scope of the bill to affect more people while narrowing the mandate to those situations where good medical practice indicates a need for the testing or treatment.

With these amendments, our opposition to H 2446 is philosophical only. Thank you for consideration of our views.

House Comm on Ins.
Feb 20, 2001
Attachment 9

The University of Kansas Medical Center

DIVISION OF ENDOCRINOLOGY, METABOLISM AND GENETICS

School of Medicine
Department of Internal Medicine

Staff
R. Neil Schimke, M. D., Director
Joseph L. Kyner, M. D.
Barbara P. Lukert, M.D.
Betty M. Drees, M.D.

Genetic Counselor
Debra L. Collins, M. S.

Nurse Clinicians
George Ann Eaks, R. N.
Beth Lucasey, R. N.

February 2, 2000

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

RE: HB 2770

Dear Chairman Tomlinson,

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

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

Reimbursement should be assured for bone mass measurements for:

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

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

I hope that these recommendations will be helpful.

Sincerely,

Barbara P Lukert, MD

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

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

1 Session of 2001
2
3
HOUSE BILL No. 2446
4
5 By Representatives Ballard and Pottorff, Barnes, Bethell, Burroughs,
6 Compton, Crow, Findley, Flaharty, Garner, Gilbert, Henry, Horst,
7 Kirk, Kuether, Landwehr, M. Long, McClure, McKinney, Minor, Judy
8 Morrison, Nichols, Pauls, E. Peterson, Phelps, Ray, Reardon, Ruff,
9 Sharp, Showalter, Storm, Swenson, Toelkes, Wells, Welshimer and
10 Winn
11
12 2-7
13

14 AN ACT concerning insurance; relating to diagnosis and treatment of
15 osteoporosis.
16
17 *Be it enacted by the Legislature of the State of Kansas:*
18 ~~Section 1. This act shall be known and may be cited as the "bone~~
19 ~~mass measurement coverage act."~~
20 ~~Sec. 2. (a) The legislature hereby finds the following:~~
21 (1) Osteoporosis affects 25 million Americans and each year results
22 in 1.5 million fractures of the hip, spine, wrist and other bones, costing
23 the nation at least $18 billion;
24 (2) osteoporosis progresses silently, in most cases undiagnosed until
25 a fracture occurs, and once a fracture occurs, the disease is already ad-
26 vanced, and the likelihood is high that another fracture will occur;
27 (3) one in two women and one in five men will suffer a fracture due
28 to osteoporosis during their lifetime;
29 (4) because osteoporosis progresses silently, and, currently has no
30 cure, early diagnosis and treatment are key to reducing the prevalence
31 and devastation of this disease;
32 (5) medical experts agree that osteoporosis is preventable and treat-
33 able; however, once the disease progresses to the point of fracture its
34 associated consequences often lead to disability, institutionalization and
35 exact a heavy toll on the quality of life;
36 (6) given the current national focus on health care reform and the
37 reduction of unnecessary health care expenditures through the use of
38 health promotion programs, bone mass measurement, related to the early
39 diagnosis and the timely treatment of osteoporosis is a cost effective ap-
40 proach to embrace;
41 (7) bone mass measurement is a reliable way to detect the presence
42 of low bone mass and to ascertain the extent of bone loss to help assess
43 ~~the individual's risk for fracture, and this aids in selecting appropriate~~

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~~10-4~~

1 therapies and interventions; ordinary x-rays are not sensitive enough to
2 detect osteoporosis until 25-40% of bone mass has been lost, and the
3 disease far advanced;
4 (8) while there are currently available technologies for bone mass
5 measurement, other technologies for measuring bone mass are under
6 investigation and may become scientifically proven technologies in the
7 future; and
8 (9) scientifically proven technologies for bone mass measurement and
9 other services related to the diagnosis and treatment of osteoporosis can
10 be used effectively to reduce the pain and financial burden that osteo-
11 porosis inflicts upon its victims.
12 (b) The purpose of this act is to provide insurance coverage to indi-
13 viduals with a condition or medical history for which bone mass meas-
14 urement (bone density testing) is determined to be medically necessary
15 for the individual's diagnosis and treatment of osteoporosis.
16 Sec. 3. Any individual or group health insurance policy, medical serv-
17 ice plan, contract, hospital service corporation contract, hospital and med-
18 ical service corporation contract, fraternal benefit society or health main-
19 tenance organization which provides coverage for accident and health
20 services and which is delivered, issued for delivery, amended or renewed
21 on or after July 1, 2001, shall be deemed to include coverage for services
22 related to diagnosis, treatment and appropriate management of osteo-
23 porosis. The services may include, but need not be limited to, all food
24 and drug administration approved technologies, including bone mass
25 measurement technologies, as deemed medically appropriate.
26 Sec. 4. This act shall take effect and be in force from and after its
27 publication in the statute book.
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Sec. 1

,

, municipal group-funded pool, and the state employee health care benefits plan

hospital, medical and surgical services other than Medicare supplement policies or accident-only policies

when such services are provided by a person licensed to practice medicine and surgery in this state, for individuals with a condition or medical history for which bone mass measurement is medically indicated for such individual. In determining whether testing or treatment is medically indicated due consideration shall be given to peer reviewed medical literature. For purposes of this act, peer-reviewed medical literature means a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. A policy, provision, contract, plan or agreement may apply to such services the same deductibles, coinsurance and other limitations as apply to other covered services.

Sec. 2

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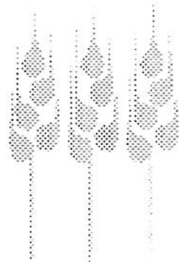
10-5



Kansas Association of Health Plans

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Testimony before the
House Insurance Committee
<u>Hearings on HB 2446</u>
February 20, 2001

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 all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid HMO's and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on HB 2446.

The KAHP appears today in opposition to HB 2446. This bill mandates that a health insurer provide coverage for bone density testing regardless of age or medical history.

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

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

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Feb 20, 2001
Attachment # 10

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. 40-2249a. This statute which was passed by the Legislature two years ago, requires the testing of any new mandate first on the state employees health plan in order to help determine its cost impact.

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

LEGISLATIVE TESTIMONY

The Unified Voice of Business

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HB 2446 February 20, 2001

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 for Legislative Affairs for the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to comment on the subject of mandated health insurance coverage and explain why the Kansas Chamber opposes passage of HB 2446.

> 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.

First, let me stress an overriding concern KCCI has expressed in this Committee many times over the past several years. Establishing what must be in an insurance product through the imposition of legislative will is no way to build an insurance product for private sector employers to

r their employees. KCCI's general principles for opposing insurance mandate proposals are summarized below.

- Government mandates show a lack of trust in the private insurance marketplace and its ability to develop an insurance product to meet the needs of insurance consumers. Please remember that, while you listen to mandate bills on the inadequacy of today's insurance product, that the majority of Kansans insured today are because of the private initiative of their employer.
- A mandate calls for something to receive greater insurance coverage than it is receiving today. Expanded coverage comes at a cost. When it is a state insurance mandate, the impact of higher insurance costs is felt by small employers and individuals. Those insurance consumers are also the most challenged in locating affordable health insurance.
- Mandate debates before the Kansas legislature are typically driven by emotional appeals. There are no unappealing mandates. Link by link, they make the chain of required coverages longer and longer.
- A mandate and a tax increase are very similar. In both, the cost of a service to a selected group of people are socialized to a larger group. In the case of mandates, all insurance purchasers pay higher costs so a group of individuals can receive the additional benefit.

Thank you for the opportunity to comment of HB 2446. I would be happy to answer any questions.

11-2

HOUSE BILL 2422 – Re: License Reinstatement and Uninsured Vehicles

TESTIMONY BEFORE THE KANSAS HOUSE COMMITTEE
ON INSURANCE
BY REPRESENTATIVE KAREN DIVITA
FEBRUARY 20, 2001

Dear Mr. Chairman and Committee Members,

Thank you for this opportunity to present information regarding House Bill 2422. This bill has been brought to you for consideration because the current law fails to provide any mechanism for reinstatement of a suspended license when the uninsured motorist or owner has fulfilled the requirements of current law by insuring the vehicle and paying the damages, but cannot gain a release from the other party. Why, you may ask, should this matter? It matters because the violator has done all that he or she can to rectify the situation but he or she cannot gain reinstatement of the suspended license because reinstatement depends on the other party.

Without any doubt, each of us recognizes the importance of insuring all vehicles that operate on our roadways. Each person on our roadways should be protected in the event of an accident. Injured parties must be able to recover their medical costs and for their suffering. This bill being introduced today does not change or weaken these mandates. It does, however, provide an administrative mechanism for reinstatement when the violator has done all this is possible. Other Kansas and federal laws already provide the means to recover for damage to property and liability resulting from injury.

Unfortunately, the current law creates a "Catch- 22" with no way out. Unless the other party provides a release from liability, the suspended license cannot be reinstated. The violator is stuck without a license long after making restitution, simply because the other party fails to respond to letters, phone calls, or cannot be found. This places an undue burden on the violator who has done all that he can to meet the current statute. Without a valid license, he or she cannot drive to work, school, childcare, doctor appointments, a myriad of essential daily activities are severely impaired. Because driving is such an important daily activity and few places if any have adequate public transportation, these people who are stuck in this "catch –22" sometimes drive while their licenses are suspended simply because they have no other means to get to work. If they have no means of transportation to work, they can't earn a living and support themselves or their families. Is this what the Legislature intended? Of course it is not!

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House Bill 2422 is an amendment for a common sense remedy to create fair balance in the current law. An administrative hearing would provide the opportunity to end the "catch-22", and allow the motorist or owner to maintain a job, take care of family needs and meet the obligations of daily life. Thank you for your consideration of this measure.