Approved: March 20, 2003
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Patricia Barbieri-Lightner at 3:30 on February 13, 2003 in Room 526-S of the Capitol.

All members were present except: Excused: Ray Cox

Committee staff present: Bill Wolff, Legislative Research
Ken Wilke, Revisor of Statutes
Renae Hansen, Secretary

Conferees appearing before the committee: **Representative RJ Wilson**, District #3, Kansas House of Representatives
**Janet Mayhew**, Licensed Cosmetologist, Pittsburg Kansas
**Jackie Graebel**, Teacher, Survivors Committee Spokesperson American Cancer Society
**Karen Carlin**, Executive Director, The Leukemia & Lymphoma Society
**George Dahlman**, Vice President of Public Policy, The Leukemia & Lymphoma Society, Washington DC
**Dr. Marcus A. Neubauer**, MD, Oncologist, Overland Park Kansas
**Bret G. Wilson**, Constituant of the 24th district of the House of Representatives
**Bill Sneed**, Health Insurance Association of America
**Terry Leatherman**, Vice President of Legislative Affairs for the Kansas Chamber of Commerce and Industry
**Representative Paul Davis**, 46th District, Kansas House of Representatives

Others attending:44 total some of whom signed the attached register.

Chair Representative Barbieri-Lightner called the meeting to order.

Before the hearings on **HB 2184, HB 2069**, and **HB 2185** were heard, Chair Barbeiri-Lightner presented the committee with Kansas statutes 40-2248, 40-2249, and 40-2249a. (attachment #1). These statutes clearly require that the impact of proposed mandate health coverage include at the minimum a series of research results on how the proposed legislative mandate would affect the social and financial aspects of enacting said proposed legislation. Furthermore, it was stated that these impact studies needed to be Kansas specific research, as Kansas Legislators needed to be able to assess how these mandated bills would affect the citizens and budget of Kansas. Barbieri-Lightner stated that unless the studies were here today the bills would not be heard today, exceptions would be made for individuals who traveled from out of state, or long distance in state if no impact statements were presented. Those from Kansas City and Wichita would not be heard today unless the bill they are speaking on has those proposed impact statements available. In addition, because of the large number of conferees present, it was asked if all conferees please limit their testimony to three to five minutes.

The hearing on **HB 2184** was opened by Barbieri-Lightner:

**HB 2184**: **Requiring coverage for wigs or scalp prostheses for any person receiving cancer treatment or related therapy**.

Representative RJ Wilson (attachment #2) explained why he came to introduce **HB 2184** on request of Janet Mayhew, a constituent from Pittsburg, who approached him on this matter after her fathers battle with cancer. It was noted that no impact statements were available.

Janet Mayhew, (attachment #3), licensed cosmetologist, Pittsburg Kansas, spoke on the way that prosthesis wigs for cancer patients helped the patients deal with the cancer treatment better and often times had a more positive outcome of their treatment with the availability of the more natural looking wigs.

Questions were posed by: Representative Scott Schwab.

Jackie Graebel, (attachment #4), Kansas School teacher, Survivors Committee Spokesperson, American Cancer Society, gave personal testimony of her cancer treatment experience and the impact the loss of hair during cancer treatment had on her and her life.

Opponents were noted to be in town conferees. Since no impact statements were provided, the hearings for **HB 2184** were closed by Barbieri-Lightner.

The hearing on **HB 2069** was opened by Chair Barbieri-Lightner.

**HB 2069: Insurance coverage for expense of participating in clinical trials.**

The Kansas impact study was requested by Barbieri- Lightner from the sponsor of the bill. Karen Carlin responded by informing the committee that the impact statement was included in the packet that was handed out to the committee. (Attachment #5)

George Dahlman, Vice President of Public Policy, The Leukemia & Lymphoma Society, Washington DC, (attachment #6) spoke to the committee in support of **HB 2069** which would provide insurance coverage for the routine patient care costs that deal with patients involved in clinical trials. Many patients still receive the standard treatments for their healthcare; however many patients need to look for other treatments that will better serve their disease or illness. Data suggest the costs of these services would be very minimal. A personal example of the success of clinical trials and its benefits to the conferee were shared.

Questions were asked by: Representatives Stephanie Sharp, Mario Goico, and Scott Schwab.

The Chair posed a question to the revisor Ken Wilke, and was answered by Researcher Bill Wolff.

Dr. Marcus A. Neubauer, MD, Oncologist, Overland Park Kansas, (attachment #7) spoke to the committee in support of **HB 2069.** Clinical trials allow for the treatment of patients diseases and illnesses to be updated and made more affective and patient friendly. Clinical trials are experimental but experimental doesn't mean irrational or unjustified. Experimental means trying to improve upon the currently available treatment. Medicare's position on clinical trial is reasonable. They pick up routine costs, while the sponsoring agent of the trial pick up the unique costs.

Bret G. Wilson, Constituent of the 24th district of the House of Representatives, father of Leukemia patient, (attachment #8), shared his families experience with his daughter Erins diagnosis. Bret also shared specifically the insurance issues involved.

Comments were presented by: Representative Bonnie Sharp, ranking minority leader.

Opponents were then heard.

Bill Sneed, Health Insurance Association of America, (attachments #9 & 10), representing the commercial insurers that write health insurance, as an industry take a position in opposition to all mandates for health insurance. Mandates typically affect only 30-35% of health insurance out there; because of federal law, self insured plans are exempt from state law. Additionally, unless a specific government entity takes specific action to accept the mandate, state mandates will not apply to the government type programs. No one mandate really costs that much, but collectively they add up.

Questions were posed by Representatives David Huff, and Nancy Kirk. Nancy Kirk asked specifically for impact statements from the insurance companies and how these mandates affected the citizens of Kansas from the Insurance companies point of view.

Larrie Ann Lower, Kansas Association of Health Plans, (attachment #11), appeared in opposition of **HB 2069** and the other two bills presented today. Collectively, mandates do have an impact on insurance costs. Questions were raised if the intent of the proponents were to eventually shift the burden of the costs of these experimental treatments to the insurance companies.

Chair Barbieri-Lightner questioned the date that the impact studies were performed.

Questions were posed by Representatives Nile Dillmore, Scott Schwab and Bonnie Sharp. Dillmore and Schwab asked questions that would compare laws currently on the books in other states, specifically Maryland, and how these laws compare to the proposed Kansas Law and fiscally the impact that this law has had on their state. Bonnie Sharp questioned the impact of the positive affects of enacting a bill that has so many gains. Can the cost increase really outweigh the benefits?

Chair Barbieri-Lightner submitted the fiscal note From the Kansas Division of the Budget (attachment #12). It states that our own Kansas employee coverage could be affected at a cost of $1.50 - $8.90 per member, costing the state an increase in HMO coverage an additional $323,550 to $1,919,730 for the current 17,975 employees under the plan.

Terry Leatherman, Vice President of Legislative Affairs for the Kansas Chamber of Commerce and Industry, (attachment #13) presented opposition to **HB 2069** and all mandate bills that pose an additional occurrence of the government imposing rules on the private insurance companies.

Questions were posed by Representatives Cindy Neighbor and Mario Goico. Mario Goico questioned the statement that these clinical trials did not deal with life threatening situations, noting that the clinical trials would not even be conducted if they were not life threatening.

Chair Barbieri-Lightner closed the hearings on **HB 2069.**

The hearing on **HB 2185** was opened by Chair Barbieri-Lightner.

**HB 2185: Insurance; providing coverage for contraceptives.**

Representative Paul Davis, 46th District, Kansas House of Representatives, a proponent for **HB 2185** and Chair Barbieri-Lightner had a discussion as to whether or not the impact studies required by law were included in Representative Davis' testimony. Chair Barbieri-Lighter allowed Representative Davis to go ahead with his testimony while she evaluated the validity of his statement that the impact studies were included as per the statutes.

Representative Paul Davis (attachment #14) presented testimony that gave reasons why insurance mandate was necessary for contraceptives. It was noted that mandates need to be looked at on an individual basis and not group them all together. This mandate is believed to be cost neutral and may in fact result in cost savings.
In 1998 federal law mandated coverage for contraceptives and they have been able to look back now and see that it did not increase the costs. The states costs would be negligible for the mandate of other FDA approved contraceptives. Rep. Davis recommended if the committee decided to act favorably on the bill that an amendment would be added to the language that would exempt this from the test track position, because we've already tested it in the state employee process. We already know what it's doing from the state position so there is no need to prolong the process.

Representative Barbieri-Lightner strongly disagreed that Representative Davis presented the committee with an impact report that is related to Kansas. It was noted that the proponents for the bill were not from out of state or further than Pittsburg, Kansas. The hearing was closed on **HB 2185.**

Meeting adjourned. Next meeting February 18, 2003.

# HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: February 13, 2003

| NAME | REPRESENTING |
|---|---|
| Rich Gattlin | Health Midwest |
| Marsha Strahm | CWA of Ks. |
| Karen Kaufholder | CWA of KS. |
| Judy Smith | CWA of KS |
| Sharon Johnson | HCA/NP |
| Rebecca Zepicle | Federico Consulting |
| Janet Mayhew | Self |
| Jacque Grable | |
| Jean Griffith | |
| Jerry Vella | KID |
| JoAnn Benton | KID |
| David Lothes | KID |
| Ron Seeber | Hein Law Firm |
| Hal Hudson | NFIB/KS |
| Bill Sneed | NIAA |
| Heidi Parmenter | self |
| Kathleen Harris | PKD |
| Sylvia J. Ruffff | KS. NOW. |
| Ruth E. Williams | Kansas Federation of Business & Professional Women (BPW/Kansas) |
| Jennifer McAdam | Planned Parenthood |

# HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: February 13, 2003

| NAME | REPRESENTING |
|---|---|
| Rick Guttau | Health Midwest |
| Cheryl Dillard | Coventry Health Care |
| Thelma Bowhay | SRS / HCP |
| Jayne A Aschemeyer | Rep. Flaharty |
| H Bosse | Dept of Admin |
| Jason Lockhart | CHLW |
| Michelle Brooks | Intern - Rep. B. Sharp |
| Elizabeth Kinch | KS Leukemia & Lymphoma Society |
| Dana Mathia | KS Leukemia & Lymphoma Society |
| Karen Carlson | Ks. Leukemia Lymph Soc |
| George Dahlman | Leukemia & Lymphoma Society |
| Marc Menbrener, M.D | Leukemia & Lymphoma Society |
| BRET G. WILSON | LEUKEMIA & LYMPHOMA SOCIETY |
| Christina Collins | Kansas Medical Society |
| Steve Montgomery | United Healthcare |
| Kevin Davis | Am. Family Ins |
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plovee or 50% of the total amount paid by the employer during the taxable year. In the fourth year, the credit shall be equal to 50% of the lesser of $35 per month per employee or 50% of the total amount paid by the employer during the taxable year. In the fifth year, the credit shall be equal to 25% of the lesser of $35 per month per employee or 50% of the total amount paid by the employer during the taxable year. For the sixth and subsequent years, no credit shall be allowed.

(c) If the credit allowed by this section is claimed, the amount of any deduction allowable under the Kansas income tax act for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with law. If the credit allowed by this section exceeds the taxes imposed under the Kansas income tax act for the taxable year, that portion of the credit which exceeds those taxes shall be refunded to the taxpayer.

(d) Any amount of expenses paid by an employer under this act shall not be included as income to the employee for purposes of the Kansas income tax act. If such expenses have been included in federal taxable income of the employee, the amount included shall be subtracted in arriving at state taxable income under the Kansas income tax act.

(e) This section shall apply to all taxable years commencing after December 31, 1999.

**History:** L. 1990, ch. 157, § 8; L. 1999, ch. 110, § 4; July 1.

**Law Review and Bar Journal References:**
"1999 Legislative Wrap Up." Ron Smith, 68 J.K.B.A. No. 7, 16 (1999).

**40-2247. Same; exemption from insurance premium tax.** No premium tax shall be due or payable on a health benefit plan established under this act.

**History:** L. 1990, ch. 157, § 9; July 1.

✱ **40-2248. Mandated health benefits; impact report to be submitted prior to legislative consideration.** Prior to the legislature's consideration of any bill that mandates health insurance coverage for specific health services, specific diseases, or for certain providers of health care services as part of individual, group or blanket health insurance policies, the person or organization which seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses both the social and financial effects of the proposed mandated coverage. For purposes of this act, mandated health insurance coverage shall include mandated optional benefits. It shall be the duty of the commissioner of insurance to cooperate with, assist and provide information to any person or organization required to submit an impact report under the provisions of this act.

**History:** L. 1990, ch. 162, § 1; July 1.

✱ **40-2249. Same; contents.** The report required under K.S.A. 40-2248 for assessing the impact of a proposed mandate of health coverage shall include at the minimum and to the extent that information is available, the following:

(a) The social impact, including:

(1) The extent to which the treatment or service is generally utilized by a significant portion of the population;

(2) the extent to which such insurance coverage is already generally available;

(3) if coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(4) if the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(5) the level of public demand for the treatment or service;

(6) the level of public demand for individual or group insurance coverage of the treatment or service;

(7) the level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and

(8) the impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage.

(b) The financial impact, including:

(1) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;

(2) the extent to which the proposed coverage might increase the use of the treatment or service;

(3) the extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;

(4) the extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and

(5) the impact of this coverage on the total cost of health care.

**History:** L. 1990, ch. 162, § 2; July 1.



✱ **40-2249a. Same; state employee group pilot project for new mandated health benefits.** (a) After July 1, 1999, in addition to the requirements of K.S.A. 40-2248 and 40-2249, and amendments thereto, any new mandated health insurance coverage for specific health services, specific diseases or for certain providers of health care services approved by the legislature shall apply only to the state health care benefits program, K.S.A. 75-6501, *et seq.*, and amendments thereto, for a period of at least one year beginning with the first anniversary date of the state health care benefits program subsequent to approval of the mandate by the legislature. On or before March 1, after the one year period for which the mandate has been applied, the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, a report indicating the impact such mandated coverage has had on the state health care benefits program, including data on the utilization and costs of such mandated coverage. Such report shall also include a recommendation whether such mandated coverage should continue for the state health care benefits program or whether additional utilization and cost data is required.

(b) The legislature shall periodically review all health insurance coverages mandated by state law.

**History:** L. 1999, ch. 162, § 5; July 1.

**40-2250. Insurance coverage to include reimbursement for services performed by advanced registered nurse practitioners.** (a) Notwithstanding any provision of an individual or group policy or contract for health and accident insurance delivered within the state, whenever such policy or contract shall provide for reimbursement for any services within the lawful scope of practice of an advanced registered nurse practitioner within the state of Kansas, the insured, or any other person covered by the policy or contract, shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or an advanced registered nurse practitioner.

(b) Notwithstanding the provisions of subsection (a), reimbursement shall be mandated with respect to services performed by an advanced registered nurse practitioner in Douglas, Johnson, Leavenworth, Sedgwick, Shawnee or Wyandotte counties.

(c) The provisions of subsection (b) shall expire on July 1, 1998.

**History:** L. 1990, ch. 162, § 3; L. 1993, ch. 137, § 1; July 1.

**40-2251. Statistical plan for recording and reporting premiums and loss and expense experience by accident and health insurers; compilation and dissemination; secretary of health and environment to serve as statistical agent; assessments; penalties for failure to report.** (a) The commissioner of insurance shall develop or approve statistical plans which shall be used by each insurer in the recording and reporting of its premium, accident and sickness insurance loss and expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner and other interested parties in determining whether rates and rating systems utilized by insurance companies, mutual nonprofit hospital and medical service corporations, health maintenance organizations and other entities designated by the commissioner produce premiums and subscriber charges for accident and sickness insurance coverage on Kansas residents, employers and employees that are reasonable in relation to the benefits provided and to identify any accident and sickness insurance benefits or provisions that may be unduly influencing the cost. Such plans may also provide for the recording and reporting of expense experience items which are specifically applicable to the state. In promulgating such plans, the commissioner shall give due consideration to the rating systems, classification criteria and insurance and subscriber plans on file with the commissioner and, in order that such plans may be as uniform as is practicable among the several states, to the form of the plans and rating systems in other states.

(b) The secretary of health and environment, as administrator of the health care database, pursuant to K.S.A. 2000 Supp. 65-6804, and amendments thereto, shall serve as the statistical agent for the purpose of gathering, receiving and compiling the data required by the statistical plan or

# State of Kansas
# House of Representatives

R.J. WILSON
Assistant House Democratic Leader

State Capitol
Room 327-S
Topeka, Kansas 66612-1504
(785) 296-7675

## Office of the Democratic Leader

**Testimony in Support of**
**House Bill 2184**
**13 February 2003**

Madam Chair and members of the committee:

Thank you for the opportunity to appear as a proponent on HB 2184, commonly referred to as the wig bill for cancer patients. I am R.J. Wilson, State Representative from Pittsburg. I am sincerely appreciative for your willingness to have a hearing on this matter. In the past such hearings have not occurred and I believe it is of great credit to the Insurance Committee, and its chairman, that this bill, and the other bills on the agenda for today are receiving a fair and complete hearing.

HB 2184 stems from a request of a constituent in Pittsburg. Janet Mayhew, who will be appearing today, approached me about this measure after her father's battle with cancer. Serious, life threatening cancer has never touched my family directly, but I watched my wife's mother lose her struggle with the illness. But out of those two tragedies some good has occurred.

Janet's family, and my wife's family have become seriously involved in American Cancer Society events locally and on the state level. These dedicated volunteers are committed to making a difference, daily, on behalf of their loved ones and the survivors of cancer. You will not find a more dedicated member to this cause in my community than Janet Mayhew. She is here today to speak with you about HB 2184. I am not an expert on this legislation Madame chairman, but I am sure that non-partisan staff and Mrs. Mayhew will be able to answer your questions and give you a better explanation of the contents of the bill.

Thank you for allowing me to appear and introduce Janet, who is also escorted for Jacque Grable, a cancer survivor from Pittsburg. Thank you madame chairman and I will be happy to stand for questions or defer to Janet.

House Insurance
Date: 2-13-03
Attachment # 2

February 13,2003

I, Janet Mayhew, of Pitttsburg, Kansas wanted to speak to you today to ask for your assistance on an issue that would make a difference in the lives of thousands of Kansans while not pulling any money from the state treasury.

For some time now, I have been trying to get a bill passed requiring insurance companies to pay for wigs for cancer patients. I have only found four regular insurance companies that do so today.

I'm sure many of you have been touched by cancer. I lost my Father, Charles Bloomcamp, to cancer. It changed my life. I have been a licensed cosmetologist for the last 15 years. I work with the American Cancer Society, Cosmetic, Toiletry, Fragrance Association Foundation and the National Cosmetology Association on the Look Good... Feel Better program. I not only do patient sessions but I also am the area trainer for southeast Kansas. I have been active with the Look Good...Feel Better program for seven years now. I did my first patient session two weeks before my father passed. I saw the changes his body went though and knew being a hairdresser that this is something I needed to do.

I am currently working at the cancer center in Pittsburg. I know more now how insurance is needed to help cancer victims with their wigs and turbans. So many people can barely afford to have treatments and to live normal lives. These circumstances mean that purchasing a wig is out of the question. A lady can hide her breast, after she has a mastectomy, but she cannot hide her hair. Although many people are comfortable with the loss of their hair, there are many more our there that have a difficult time looking in the mirror to see there is a stranger looking back at them. Whenever I help someone get fitted for their wig the first time, I can see the difference it makes in them.

House Insurance
Date: 2/13/03
Attachment # 3

After cutting and shaping the wig, I can see the smile come back to their face and I notice a change in their overall confidence.

I am writing asking for your assistance in getting a bill passed to mandate coverage for alopecia due to medical reasons. You would be helping many people. Not just the person with the cancer but the whole family, and friends of the patient. Aside from the medical benefit of helping people feel better about their appearance, such a bill would allow people who are enduring great suffering the opportunity to better their self esteem and to live productively during their affliction. Cancer victims could then do things such as go to a school play, go to church, go to the store etc. So many people do not feel as beautiful or handsome as they are if they do not have hair. With a wig they look like everyone else and don't have to worry about the stares and quiet discussions about their appearance.

Of all the patients at Mt.Carmel Regional Cancer Center 35% do not have hair. Of these patients 95% cannot afford to have a wig. The patient is stuck with a donated wig of the wrong color or style. The patient has hair now but still does not feel as beautiful or handsome as they could if she or he had the correct color and style. With the insurance paying for this as they do prosthesis she could get the correct style and color. That is just as important as having the right size prosthesis. This is a very small percentage of people here in Kansas.

I have been very fortunate that R.J. Wilson has been helping me on this cause, He knows how passionately I feel about this issue. I helped to get the bill passed in Oklahoma by having several patients sign petitions in favor of such legislation. Daily, I see what these patients go through and I want to help them. Please help me, to help them.

Mt. Carmel Regional Cancer Center

February 11, 2003

Dear Committee Members of our Kansas Legislation,

As current practicing medical and radiation oncologists at Mount Carmel Regional Cancer Center in Pittsburg, Kansas, we would like to strongly give our support in favor of House Bill #2184.

In our practice we see numerous patients going through chemotherapy and/or radiation therapy on a daily basis. Several recent surveys and studies have shown that hair loss during therapy is the single most important concern of patients, especially women. Alteration of self image is an important issue that our patients face. This causes a tremendous amount of stress in them. We've had several patients refuse to undergo potentially beneficial treatment, just to avoid hair loss.

A hair prosthesis is a small consolation for these patients and may ease some of the stress faced by them. Nationally, a few major insurance carriers already cover hair prostheses for medical reasons. House Bill #2184 is to mandate this coverage for all Kansans for medical reasons.

In conclusion we request the esteemed members of this Kansas Legislature to join us in wholeheartedly supporting House Bill #2184.

Thanking you,

Boban N. Mathew, MD
Medical Oncology/Hematology
Medical Director of Oncology Program

Renee Plumb, MD
Medical Oncology/Hematology

Ibraham Gobar MD
Medical Oncology/Hematology

Jose Pacheco MD
Radiation Oncology

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2/13/03
4

Feb. 12, 2003

I, Jacque Grable, of Pittsburg, Kansas would like to take this opportunity to speak to you about the importance a wig can have in the lives of many cancer patients. I come to you not only as a cancer patient but also as a friend of many cancer patients. I am currently an active participant, as well as the Survivors Committee Spokesperson, for the American Cancer Society's Relay For Life in the Crawford County area.

For many years I have witnessed the devastation cancer treatment has had on people. I've watched as several family members and friends have fought off this disease. I have seen and felt the tears that have been shed, not only because of the illness but, the terrible side effects the treatment has caused. I remember my grandmother and, more recently, my mother worrying and crying daily because they didn't know how they could possibly afford to have this disease. They were devastated about loosing their hair and wanted so desperately to be able to afford something as simple as a wig. We used to joke about loosing our breast and how insurance would pay for a prosthesis but not for a wig. For many of us hair was, and still is, much more important than having heavy breasts weighing us down.

I personally lost both my breast and my hair at a very young age, (34). I remember the doctor asking me if I would be interested in reconstructive surgery, after all my insurance would pay 100%. I smiled and said, "no thank you but, could you please put that $35,000.00 toward the purchase of some wigs for those of us who can not afford them." You see, while breast are important to some, having hair is so much more a natural part of who we are. Being completely bald can be devastating to a persons self esteem. Unfortunately, in today's society, our appearance is how many people judge us. A person who is bald, especially a female, is viewed as unacceptable, an outcast, and a freak.

As an Elementary School Teacher I have had the stares and rude comments thrown at me a few times. Once, I had a student run out of my class screaming because he thought I was strange. For several months he saw me with a full head of hair then one day I had none. I had worn a turban to work that day because I could not afford to purchase a wig. I have been very fortunate since then and have received a couple of wigs as gifts.

There are many obstacles we, as cancer patients, must face and overcome on a daily basis. We have the disease itself, surgeries, life and death decisions, quality and quantity of life, astronomical medical bills, treatment options and their numerous side effects along with worrying about how we appear to others. There are enough obstacles and decisions to be made without having to worry about being able to afford a wig. Please do not continue to make this one of our many worries. This BILL is a MUST! With the passing of this bill you will be helping thousands of people, like myself, regain a little dignity and self confidence.

Sincerely,

Jacque Grable

House Insurance
Date: 2-13-03
Attachment # 4

**Kathleen Sebelius**
Commissioner of Insurance
**Kansas Insurance Department**

January 14, 2002

Ms. Karen Carlin
The Leukemia & Lymphoma Society
555 N. Woodlawn, Bldg. 1, Ste. 113
Wichita, KS 67208

Dear Karen:

K.S.A. 40-2248 and 40-2249 requires persons or organizations seeking legislation that proposes a mandate of services or providers to provide a social and fiscal impact report. Your organization requested that the Kansas Insurance Department assist in asking companies involved in accident and health insurance to provide information regarding coverage for clinical trials, including coverage for related drugs and devices.

The Accident and Health Division of the Kansas Insurance Department requested information from a few of the larger insurers in this state, in order to obtain a general sampling. The Department provided a copy of the Maryland law to the insureds and asked what the cost impact would be should this law be passed in Kansas.

We received answers from Preferred Plus of Kansas, Blue Cross & Blue Shield of Kansas, and Coventry Health Care of Kansas. United Health Care did not respond to our requests. The following information was received:

Preferred Plus of Kansas

- Phase I trials are not conducted in Wichita
- Phase II & III trials are covered, if not paid for by the organization conducting the trial.
- The organization will usually provide drugs/devices without charge
- Cost Impact – minimal

Blue Cross & Blue Shield of Kansas

- Generally, their comment is that the usually pay for the necessary service for trial for two reasons: Unable to determine by coding the different between clinical trial service and non-clinical trails and usually the trial is beneficial to the member, so denial of payment is difficult.

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Topeka, Kansas 66612-1678
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Fax 785 296-2283
Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

- They checked with the Maryland (BCBS) plan and their analysis showed a minuscule claim impact and a nonexistent rate impact.

Coventry Health Care of Kansas

- Many, but not all clinical trials are paid, therefore there is not enough data to support predictions on cost impact in Kansas. However, information was obtainable from the Maryland office.

- Cost impact: $1.50 to $2.00 per member/per month.

Please feel free to contact us should you need further information regarding this matter.

Sincerely,

Linda J. De Coursey
Director of Government Affairs

Preferred
Health Systems

January 23, 2002

Ms. Karen Carlin
Executive Director
The Leukemia and Lymphoma Society
Kansas Chapter
555 N. Woodlawn, Suite 113
Wichita, KS 67208

Re: Coverage for Clinical Trials

Dear Karen:

As we have discussed recently, the health benefit plans offered by Preferred Plus of Kansas and Preferred Health Systems Insurance Company currently limit coverage for experimental or investigational treatment to approved clinical trials. We have reviewed the bill introduced in the House Insurance Committee on January 22, 2002, by the Kansas Chapter of the Leukemia and Lymphoma Society, which mandates coverage of clinical trials and determined it would not have a cost impact on our benefit plans.

While we believe the specifics of health plan benefits should be determined by the private market rather than through government mandates, since we currently cover approved clinical trials, Preferred Health Systems will not oppose this bill.

If you have any questions, please do not hesitate to contact me at 316-609-2315.

Sincerely,

Bruce A. Witt, HIA, MHP
Corporate Compliance Officer

Cc: Brad Clothier
Senior Vice President
Business Development

5-3

## THE SOCIAL IMPACT OF COVERAGE OF CANCER CLINICAL TRIALS

In 2002, approximately 1,284,900 Americans will be diagnosed with cancer. In the state of Kansas, more than 12,300 individuals will be diagnosed with cancer in 2002. For many of these individuals, standard cancer treatment will be the preferred course of care. However, standard cancer treatment may not be appropriate for some cancer patients, and for certain forms of cancer that are limited standard treatment options. For individuals facing these situation, care in a clinical trial may represent the best – if not the only – treatment option.

It is estimated that the vast majority of children with cancer receive care in a clinical trial and approximately 3-5% of adults receives care in a clinical trial. Cancer researchers and patient advocates seek to increase clinical trials enrollment to include 10% of adult cancer patients, but this boost in enrollment depends not only on an assurance of reimbursement but also an expansion in the number of clinical trials admitting patients at any one time. A significant enhancement in clinical trials enrollment is in large part an issue of capacity and patient education that will be addressed only incrementally.

Coverage for the routine patient care costs for those enrolled in cancer clinical trials is available in some insurance plans and health plans, but even in those plans that cover clinical trials, there are often questions about the standards that will apply to those enrolling in clinical trials. Cancer patients in clinical trials often find that reimbursement for their care is denied on the grounds that it is "experimental" care.

When cancer patients are making a decision about the care they will receive, they consider a number of factors, including whether reimbursement will be assured. Physicians attempt to provide their patients reliable information about coverage for clinical trials and also routinely offer to obtain assurances that coverage will be granted. However, at a time of great stress when health care decisions must be made quickly, patients are reportedly often discouraged from clinical trial participation because of uncertainties about insurance payment. Physicians conducting clinical trials indicate that questions about insurance coverage can be a deciding factor in dissuading patients from participating in trials.

The impact of a lack of coverage can have two very different effects on the individual. Some individuals, faced with questions about coverage or a clear lack of coverage, may choose to forgo enrollment in a clinical trial. That may mean that the individual receives treatment that is less than optimal. Or the individual may choose to enroll in a clinical trial even tough his or her insurance plan does not cover the routine patient care costs for the trial; that individual may face significant out-of-pocket health care expenses for physician visits, laboratory tests, and other services, even though there will be no charge for the experimental treatment – often a new chemotherapy drug or other pharmaceutical agent, in the case of cancer patients.

Cancer advocacy organizations have sought coverage for clinical trials through a provision in the federal patients' bill of rights and through state legislative action. To date, 13 states have passed laws that provide insurance coverage for clinical trials, including cancer clinical trials.

Because the proposal is limited to reimbursement for the routine patient care costs for those enrolled in clinical trials; there should not be additional indirect expenses associated with coverage. There is a potential indirect benefit to such coverage, however, which is the important information about best cancer therapies that will be provided by high-quality clinical research. Most experts attribute the progress in treating some forms of childhood cancer, including certain types of leukemia, to the fact that most children with cancer enroll in clinical trails and that questions regarding the best treatment of childhood cancer are answered efficiently.

## THE FINANCIAL IMPACT OF CANCER CLINICAL TRIALS COVERAGE

It appears that there would be a minimal impact, if any, on the cost of cancer care if coverage of clinical trials were assured. Although one study concluded that care in cancer clinical trials is approximately 10% more expensive than standard cancer therapy, other studies suggest that care in clinical trials is no more expensive or may be even less expensive than standard cancer therapy.

Although it has been suggested that enrollment in clinical trials would surge if reimbursement were certain, the number of individuals who may enroll in trials is limited not only by payment concerns but by the capacity limits in the current system. The United States General Accounting Office (GAO) has also considered and essentially dismissed the potential for a "woodworking" effect; that is, the possibility that there would be a significant increase in clinical trials enrollment if reimbursement barriers were eliminated.

The choice for most cancer patients will be a choice between undergoing standard cancer therapy or enrolling in a cancer clinical trial. The choice will generally not be a choice of clinical trials enrollment or undergoing no therapy. Therefore, core provided in a clinical trial will generally supplant standard therapy for the individual patient.

It is likely that care in a clinical trial will be no more expensive than standard cancer therapy. However, there is a potential for improving the efficiency of the health care system if clinical trials can be completed and can answer critical questions regarding the effectiveness of cancer therapies. The clinical trials system can provide vital information about cancer therapies and help the health care system avoid paying for care that is not effective.

The experience in the states that have passed laws to require coverage of cancer clinical trials is not lengthy, but there is no indication that requiring coverage of such trials has increased insurance premiums or the administrative expenses of policy holders in those states.

Because the choice for cancer patients is between care in a clinical trial and standard therapy and the cost differential for care in a clinical trial is not significant; the impact of the coverage on the total cost of health care should be limited.

The Leukemia & Lymphoma Society
Fighting Blood-Related Cancers

**STATEMENT OF GEORGE DAHLMAN**

**VICE PRESIDENT OF PUBLIC POLICY**

**THE LEUKEMIA & LYMPHOMA SOCIETY**

**In Support of House Bill 2069,**

**To Provide Coverage for Expenses of Clinical Trials**

Good afternoon, I am George Dahlman, the Vice President of Public Policy for The Leukemia & Lymphoma Society. The Society is the nation's second largest voluntary cancer organization and the world's largest dedicated to the cure of blood cancers. With an annual medical research budget of almost $40 million this year and 60 chapters around the country – including Kansas – we provide a variety of patient support programs, including financial assistance, to the 110,000 Americans who will be diagnosed with these diseases each year.

It is my pleasure to be here today to express our support for House Bill 2069, which would provide insurance coverage for the routine patient care costs of individuals with cancer or other life-threatening illnesses who enroll in clinical trials.

This legislation is a matter of great importance to the patients we represent, many making difficult decisions about their treatment after receiving a diagnosis of leukemia, lymphoma, or myeloma. At a time when patients are facing tough choices about their health care, they should not also confront questions about whether their health care plan or insurance will pay for that care. We believe that a policy of coverage for routine care in clinical trials is best for the individual patient but also fosters a strong clinical trials system that yields answers about the best treatments as well as information about treatments that should no longer be pursued.

For many cancer patients, the so-called standard therapy is the best option. For others, care in a clinical trial may represent the best treatment option. At the current time, it is estimated that as few as 3 to 5% of adults with cancer enroll in clinical trials. Efforts are underway in the private and public sectors to increase this level of participation by increasing the number of cancer clinical trials and by launching educational programs to enhance awareness among providers and patients of clinical trials as a treatment option. However, we know from experience in the Society's patient services program that our clients weigh enrollment in a clinical trial very seriously, and one of their central concerns is whether their care will be paid for.

House Insurance
Date: 2-13-03
Attachment # 6

If a patient hears even a suggestion that his or her care may be classified "experimental" and therefore not reimbursed, that patient will almost certainly reject enrollment in a clinical trial. Patients will not choose to enroll in a trial if they believe that choice will mean a rejected claim or protracted negotiations with their insurers. This may mean that a patient does not receive the best treatment available.

Kansas can join more than a dozen states and the federal Medicare program by passing legislation to provide coverage for routine care in clinical trials for those with cancer and other life-threatening illnesses. In 2000, President Clinton issued an Executive Memorandum that directed the Medicare program to cover the routine patient care costs for those enrolled in clinical trials. Within a matter of months, the Medicare program had developed the standards for coverage of trials and issued them in the form of a National Coverage Determination. More than a dozen states have joined his trend toward coverage of clinical trials, thereby ensuring that citizens of those states who have private insurance will enjoy coverage for clinical trials. And a number of insurers have entered into voluntary agreements to cover the routine care costs of clinical trials.

We believe the data suggest that the cost of this legislation will be quite limited. Studies comparing the cost of care in a clinical trial to standard therapy have reached slightly varying conclusions: some have concluded that there is a modestly increased cost of care in a clinical trial, while others have concluded that there is virtually no difference in the cost of care. The experience in the states that have clinical trials coverage provisions, although of short duration, supports the conclusion that the cost of such legislation will be limited.

It is important to emphasize that the Kansas legislation, like the Medicare coverage policy and the clinical trials laws in other states, would require coverage only of routine patient care costs, or the costs that insurers would be responsible for even if the patient were receiving standard therapy. The legislation specifically excludes from coverage those items that are related to the investigation itself, including the costs associated with managing the research associated with the trial.

The benefits of this legislation are clear for those individuals who will enroll in a clinical trial. However, the advantages of this legislation reach far beyond the cancer patient who may be able to enroll in a clinical trial next year. An instructive experience is our success in improving the treatments for childhood leukemia and in boosting the percentage of children with leukemia who are cured. The vast majority of children who are diagnosed with cancer are enrolled in clinical trials, and through this clinical trials system we have made incremental and steady improvements in the treatment of childhood leukemia. Many believe that a boost in the participation of adults in clinical trials would contribute to similar incremental and steady improvements in the treatment of cancer in adults. Removing doubts about the reimbursement for participation in clinical trials must be part of any effort to enhance the adult clinical trials system.

In conclusion, let me provide a personal example that will help illustrate the potential impact of this legislation. My son had leukemia. Twenty-five years ago the survival rate for his disease was only 20 percent. 80 percent died. Fortunately, today those figures are reversed; 80 percent survive. The reason for that remarkable achievement is not due to new drugs. It is because more than 60 percent of children diagnosed with cancer are put in clinical trials – as opposed to the 3-5 percent for adults. Over that generation, doctors were able to tweak and modify protocols to gradually improve outcomes for children. And because of those trials, my son is alive today.

We firmly believe the same success can be achieved for adults if only the barriers to participation are overcome. The costs of extending routine care coverage to clinical trials are negligible –and the potential benefits to all of us are tremendous.

The Leukemia & Lymphoma Society commends the committee for its consideration of this important issue. We wholeheartedly endorse House Bill 2069 and will lend our support to its timely passage.

House Insurance
Date: 2/13/03
Attachment # 7

February 13, 2003

RE: Legislation mandating insurance companies to cover the routine costs of clinical trials

I am a medical oncologist in Overland Park, KS. I see adult patients with all varieties of cancer. I am very active in clinical research for several reasons: clinical trials expand the treatment options for our patients with potentially life threatening diseases; many cancers aren't curable so better treatments are essential; established treatments became "established" through the process of clinical trials. It is through clinical research that we have proven that women with breast cancer don't have to have a total mastectomy. That pills like tamoxifen can decrease breast cancer relapse and prolong survival. That 80% of childhood leukemias can be cured when 30 years ago, they were uniformly fatal. These are only a few of the many examples of progress through clinical research.

In the 1990's, for the first time, the incidence of annual cancer deaths was finally on the decline. This milestone is based upon improved methods of prevention, diagnosis and treatment. These accomplishments have all been gained through the clinical trial process. A clinical trial is a way to find out if a treatment may be effective and, subsequently, if that treatment is superior to established treatment. We can never make any progress in developing better therapy if we can't put patients on clinical trials. In June 2000, President Clinton issued an executive memorandum directing Medicare to "pay for the routine patient care costs…and costs due to medical complications associated with participation in clinical trials". HCFA, the government body that administers the Medicare program, developed a "National Coverage Decision" to pay for the routine costs of clinical trials and have been doing this since the end of 2000.

Still, there are some private insurers that are not willing to pay the medical bills for patients on clinical trials. I have heard excuses like, "we won't pay for this treatment because it is experimental". In my opinion, this is simply undefensible. Yes, of course, the treatment is experimental, but why is that an excuse not to pay? Experimental doesn't mean irrational or unjustified. Experimental means trying to improve upon the currently available treatment. If the status quo was guaranteed cure then there would be no need for clinical trial research, until then, there is always a need for better treatments.

I think Medicare's position is very reasonable. Medicare agrees to pay for the "routine" costs of the clinical trial. The extra costs that are unique to the trial are picked up by the sponsor (government, pharmaceutical industry). The "routine costs" of a clinical trial typically include those costs that would be generated if the patient were to be treated "off-study". For example, physician visits, established chemotherapy agents, established labs to monitor side effects, periodic imaging tests to measure the response to treatment. It is only these types of costs that we would expect the insurance company to pay. So, why would an insurance company refuse to pay? To save money? I would argue that they don't save any money because if the patient wasn't treated on the trial they would be treated anyway outside of the trial. Data from the Association of Community Cancer Centers (ACCC) and the cancer prevention branch of the National Cancer Institute (which oversees community oncology research programs) have shown that clinical trials are not more expensive than standard therapies. I am not privy to the business strategies of private payors but, the only reason that I can think of to deny payment is to attempt to not pay at all, thinking if the patient doesn't go on the trial then no treatment (and, therefore, no claims) will be offered to the patient. This isn't realistic or fair.

So, in conclusion, I request legislation mandating insurance companies to pay for the routine costs of a clinical trial so that patients with life-threatening cancer have an opportunity to receive the best treatment they can get. Thank you for your attention.

Marcus A. Neubauer, M. D.

House Insurance
Date: 2-13-03
Attachment # 7

# TESTIMONY OF BRET G. WILSON

**February 13, 2003**

Good Afternoon. My name is Bret G. Wilson. I live in Overland Park, and I am a constituent of the 24th District of the House of Representatives.

My daughter, Erin, was diagnosed with leukemia over eight years ago at the age of four. After four years of chemotherapy and being off of treatment for nearly three years, she suffered a relapse in July 2001. This relapse was her second relapse and there were several other prognostic factors that indicated that further chemotherapy would not cure her disease. Thus, her oncologist in Kansas City recommended that she undergo a bone marrow transplant.

Bone marrow and stem cell transplants have, over the past twenty years, evolved into viable last chance cures for many forms of cancer and auto-immune diseases. The majority of patients that undergo bone marrow or stem cell transplants do not survive the first year post transplant due to the many complications that arise as a result of this intense treatment. Survival rates are improving, but only because of clinical trials designed by researchers to improve the procedure.

After Erin's relapse, we immediately began three weeks of research, visits, interviews and consultation to determine where she would undergo her bone marrow transplant. We ultimately selected the Fred Hutchinson Cancer Research Center in Seattle, Washington—one of the leading bone marrow transplant centers in the world. Erin underwent her bone marrow transplant in

House Insurance
Date: 2-13-03
Attachment # 8

November 2001. Unfortunately, she relapsed again in February 2002 and returned back to Kansas City with virtually no chance of survival.

Despite the setback in Seattle, Erin did not want to give up. So she underwent more chemotherapy in Kansas City in an attempt to once again induce remission. Her treatment failed to induce remission—yet Erin still refused to quit. Thus, she traveled the MD Anderson Cancer Center in Houston, Texas where she participated for six weeks in a Phase I clinical trial of a new drug called clofarex. The clinical trial was a success—against extremely long odds, Erin once again achieved remission.

After her success in Houston, Erin returned to Kansas City to again seek a permanent cure through a second bone marrow transplant in July 2002. Unfortunately, Erin died on August 6, 2002, at the age of 12, due to complications from the transplant.

At the periphery of Erin's incredible story were insurance issues. Both my wife and I had elected to cover Erin through group health insurance policies provided by our employers and administered by nationally known health insurance companies. Because my wife's birthday occurs 41 days earlier in the calendar year than my birthday, her insurance was the primary insurer. My group health insurance plan, however, provided slightly broader coverage than my wife's and would thus also cover a portion of transplant costs.

Having two group policies, we felt that we were in pretty good shape from an insurance standpoint. To our surprise, however, that was not immediately the

case as both my insurance and my wife's insurance either rejected, or indicated a clear intent to reject, our initial requests for coverage.

My insurance was the first to reject coverage of Erin's first transplant, taking what was in my view a confrontational stance. Their rejection essentially was based on the treatment protocol being "experimental" and part of a clinical study. With the help of our doctors and the financial office in Seattle, we appealed the rejection immediately and the rejection ultimately was overruled.

About a month after we resolved issues with my insurance, my wife's insurance also rejected coverage of my daughter's transplant. The basis for their rejection was merely that the results of my daughter's treatment were to be shared and included in statistical clinical test analyses. With the help of my wife's insurance case worker, we got around the rejection by changing to a treatment protocol that was identical to the original protocol in all respects except that my daughter's treatment was not to be included in a research study.

We encountered coverage insurance problems with the second transplant as well. My wife's insurance rejected coverage, and my insurance stated that they would likely reject coverage—both claiming that the treatment was experimental. Both insurers later relented, but only after we submitted a written statement explaining not only why coverage was appropriate but also in why it was their best interests to cover Erin's second transplant. A copy of our written statement is attached to this transcript as Exhibit A—it is a clear example of what we went through to ensure that Erin received the coverage to which she was entitled.

Looking back on the insurance aspects of Erin's ordeal, I am struck by three major issues.

First of all, I got the impression that some insurance companies may initially deny coverage on a clinical-trial basis to see if the patient will back down and no longer pursue coverage. Some patients may be intimidated by this bulldog approach. Some simply may not know that they can push back. And others may just not be willing to fight or may just be too tired or distracted to push back because they are consumed with other issues in dealing with a catastrophic illness. In our case, we made it very clear that we were willing to fight. I often wonder what would have happened had we been less savvy or taken less aggressive responses to our insurers' initial rejections.

Secondly, it seems as if the insurance companies take an "all or nothing" approach when it comes to clinical trials. Even if a particular protocol is minimally associated with a clinical trial or involves minimal clinical testing, the insurer may deny coverage for the entire medical procedure. In our case, the insurers denied coverage because results of Erin's treatments were to be included in a clinical statistical analyses, even though this inclusion would not have resulted in additional costs to the insurer. It seems that an insurer should pay the entire cost of the trial if such trial would cost less than then-current standard treatment protocols. It also seems that if a clinic trial costs more than a standard protocol, the insurer should pay an amount up to what the standard protocol would cost or for those portions of the clinical trial that are the same as the standard protocol.

Finally, in some cases there seems to be a callous lack of regard for what patients and their families are going through. This callousness sometimes borders on outrageousness. In our case, we were facing Erin's potential death and a multitude of other issues, including: selecting transplant facilities; finding places to live; searching for bone marrow donors; making arrangements for absences from work; making arrangements to care for our other children during our absences; making financial arrangements to cover transplant-related costs not typically covered by insurance; helping Erin prepare for the likelihood that she would die. The issue we did not expect to face, and should not have had to face, was insurance coverage—especially since we procured not one, but two, separate policies. Yet we did face insurance coverage issues, and in one case felt as if the insurance company was looking for a way out of providing coverage.

In conclusion, I would like to point out that I am not an expert in insurance matters. I am just a father who tried to save his daughter's life by doing everything I could to get her the best medical care possible. I do know, however, that patients and families facing catastrophic illnesses face many challenging, and often times overwhelming, issues. The last issue they should have to face is whether they will be denied all insurance coverage because a portion of their treatment is deemed to be a clinical trial. This is especially the case when their proposed treatment is not radically different from current protocols and would result in lower costs or at least would not result in additional costs.

Exhibit A

**Erin Andra Wilson**

**Statement in Support of Appeal of Rejected Insurance Claim**

Our daughter, Erin Wilson, will undergo a bone marrow transplant some time this summer. We understand that INSURANCE COMPANY has rejected Erin's claim for coverage on the basis that her proposed transplant treatment protocol is "experimental." We are submitting this statement on Erin's behalf as part of our appeal of INSURANCE COMPANY's initial rejection of Erin's claim. This statement will briefly summarize Erin's story and then explain why Erin's claim for insurance coverage should be approved.

## Erin's Medical History

Erin is a twelve-year-old young lady who is in the sixth grade at Santa Fe Trail Elementary School in Overland Park, Kansas. She is a straight-A student who is a member of the Santa Fe Trail Student Council. She participates in many extra-curricular activities, including drama, the Kansas City Children's Chorus, softball and competitive swimming. Despite her battle with leukemia, she has led a very productive and exemplary life.

On October 20, 1994, Erin was diagnosed with leukemia the age of four. She initially underwent a standard low-risk chemotherapy protocol at Children's Mercy Hospital in Kansas City, Missouri. After eleven months of treatment, Erin suffered a CNS relapse on September 29, 1995. She then was placed on a high-risk protocol combined with cranial radiation and omaya intrathecal therapy and successfully completed this protocol over a three-year period. After being off of treatment for nearly three years, Erin suffered a relapse on July 16, 2001.

Because Erin's July relapse was her second relapse and because certain other prognostic factors indicated that further chemotherapy would not likely cure her disease, her oncologist at Children's Mercy recommended that she undergo a bone marrow transplant. After researching and visiting various transplant centers, we opted to send Erin to the Fred Hutchinson Cancer Center in Seattle, Washington, which is considered by many to be the top transplant center in the United States for unrelated transplants. There, Erin had her transplant on November 21, 2001.

Erin's transplant went smoothly and she was doing very well until she suffered a relapse on February 25, 2002. The doctors in Seattle suggested that Erin return to Kansas City to undergo chemotherapy and then, if she were able to achieve remission, undergo a "mini-transplant." Thus, she returned to Kansas City

immediately and began a standard course of chemotherapy at Children's Mercy Hospital in Kansas City.

Unfortunately, Erin was unable to achieve remission after a month of standard chemotherapy. Erin was thus running out of treatment options. Her doctors at Children's Mercy recommended that she consider participating in a clinical trial of a drug called Clofarex being conducted at the MD Anderson Cancer Center. Erin decided that she wanted to continue her fight and thus traveled to Houston to begin treatment with Clofarex on April 1.

The Clofarex worked. Erin is now back in remission and is ready for the next step in her fight to achieve a lasting cure—a "mini-transplant."

## Why Erin's Claim for Insurance Coverage Should be Approved

For the reasons stated below, it is clear that INSURANCE COMPANY should approve coverage of Erin's mini-transplant.

1. Erin's "mini-transplant" is not "experimental" under her circumstances.

   For the reasons described below, Erin's mini-transplant is not "experimental" and rejection of coverage is not justifiable.

   a. A "mini-transplant" in Erin's clinical situation is the standard treatment option, not an "experimental" treatment.

   A "mini-transplant" is not "experimental" for some one in Erin's clinical circumstances and is, in fact, a standard treatment option for some one in Erin's clinical situation. We have discussed Erin's clinical course with three leading cancer institutions—Children's Mercy Hospital in Kansas City, Missouri, MD Anderson Cancer Center in Houston, Texas and the Fred Hutchinson Cancer Center in Seattle, Washington. All three of these institutions have confirmed that a "mini-transplant" is a reasonable clinical course of action for a person in Erin's clinical circumstances, and each has recommended that Erin undergo such a transplant after achieving remission. The unanimity of these three institutions shows that Erin's mini-transplant would not be "experimental," but is in fact a standard treatment protocol.

   b. The mere fact that Erin's "mini-transplant" may be deemed "investigational" is not a sufficient basis to reject coverage on the basis that her treatment is "experimental."

   To our knowledge, each drug to be used in Erin's mini-transplant protocol is a standard FDA-approved drug, and none of the drugs is undergoing clinical testing. The only "investigational" aspect of Erin's treatment is that

the physicians will record aspects of her transplant to gain knowledge and improve techniques. The use of information from Erin's transplant should not render her transplant "experimental." To claim otherwise simply is absurd—it would mean that any time a physician learns from a procedure, such a procedure would be "experimental" and would preclude insurance coverage.

c. The mere fact that "mini-transplants" are relatively uncommon is not a sufficient basis to reject coverage on the basis that Erin's treatment is "experimental."

It is true that "mini-transplants" are relatively new and uncommon. Yet this is because relatively few patients have achieved remission and lived long enough after a failed standard transplant to even try a mini-transplant. Thanks to medical advances proven by the clofarex clinical trial and thanks to Erin's grit, determination, fighting spirit and good health (other than her leukemia), she has earned and deserves another crack at lasting cure. We should not be penalized because of Erin's admirable character and strength and recent medical advances.

2. Erin has no other medical alternatives.

Erin is not a candidate for a typical standard transplant that may fall within INSURANCE COMPANY guidelines because of the high levels of radiation she received during her first transplant. Such a standard transplant would likely result in death and thus is not a viable alternative. Likewise, to do nothing would likely result in death and would be akin to telling her to give up and die. These alternatives simply are unacceptable—especially when considering that there have been successful mini-transplants and that Erin has fought so hard for another chance for survival. A "mini-transplant" is Erin's last chance for success.

3. There are moral, ethical, business and contractual reasons for covering Erin's transplant.

a. Denial is morally and ethically wrong.

As noted above, there are no other alternatives for Erin. Although the INSURANCE COMPANY doctors have rejected Erin's claim for coverage, they obviously are not in a position to propose alternatives. Simply denying coverage and expecting Erin to just quit and die when there is a chance for success and when she is fighting so hard is morally and ethically wrong.

b. Denial is contractually wrong.

We procured insurance coverage to deal with this very situation—to help us fight to save our child's life in the event of catastrophic illness without driving our household to financial ruin. Notwithstanding any "legal fine print," there is a contractual basis for covering Erin's claim. To deny coverage on an overly technical and tenuous claim of "experimental" treatment reeks of bad faith.

c. Coverage makes business sense.

Erin's battle for survival is well known throughout the Kansas City area and the Kansas City business community. Her battle is documented daily on the Internet (www.erinandrawilson.com) and is followed by hundreds of people throughout the world. Coverage denial would likely result in outrage and disgust within and without the Kansas City and EMPLOYER communities—it would harm EMPLOYER employee morale and result in reputational damage for EMPLOYER and INSURANCE COMPANY. Thus, coverage makes business sense.

## Summary Statement

Erin is a fighter. She has decided that she is not yet ready to give up. If Erin is not ready to give up, then no one else has the luxury of giving up—not her family, not her doctors, and not her medical insurers. Thus, we are prepared to go to great lengths to make sure she has every chance for success.

We believe that the "right" decision to cover Erin's transplant ultimately will be made. We are prepared, however, to fight as much as necessary and wherever necessary to make sure that Erin's transplant is covered, especially when it is so clear that she is entitled to coverage.

Bret G. Wilson

Christine M. Wilson

# MEMORANDUM

House Insurance
Date: 2/13/03
Attachment # 9

TO: The Honorable Patricia Barbieri-Lightner, Chair
House Insurance Committee

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

DATE: February 13, 2003

RE: H.B. 2185, H.B. 2069, and H.B. 2184

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Madam Chair, Members of the Committee: My name is Bill Sneed and I represent the Health Insurance Association of America ("HIAA"). We appreciate the opportunity to appear in opposition to H.B. 2185, H.B. 2069, and H.B. 2184. I have taken the liberty of combining my client's testimony on all three bills in order to save a few additional trees. Inasmuch as our general comments and the report on mandated benefits are applicable to all three bills, I have combined our testimony on the three. Within the text of my comments, I have inserted specific paragraphs dealing with each bill and each has been identified for the Committee's convenience.

HIAA is the nation's leading advocate for the private, market-based health care system. Our 255+ members provide health insurance to approximately 110 million Americans, many of whom are Kansas residents. HIAA's members offer a wide variety of health coverages to meet the needs of Kansas citizens, including major medical health plans, long-term care insurance, supplemental health coverage, disability income and pre-paid dental plans.

Over the last few years, more and more state policymakers have introduced legislation to require health plans to cover specific conditions or specific services. The political

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House Insurance
Date: 2-13-03
Attachment # 9

impetus for these benefit mandates arises from a number of sources. In many cases, the mandate represents a way for legislators to provide a social good with little or no impact on government spending. But however well intended, mandates ultimately harm consumers by raising the cost of health insurance and contributing to the growing number of Americans who cannot afford to purchase coverage. Thus, the HIAA has historically opposed any and all mandates considered by the Kansas Legislature.

In general, the cumulative effect of mandates is quite costly. For every 1% increase in premium costs due to mandates and other cost drivers, it is estimated that 200,000 insurers drop from coverage. Mandates cut against employer, and especially individual, choice, forcing particular coverages on purchasers who may not need nor want them and needlessly politicizing substantive health benefits in the process. Finally, mandates are especially inequitable when imposed on the individual market purchasers, who must often spend limited funds to buy coverage they will, by definition, never use, i.e., men will never use the contraceptive coverage but must pay for it.

Next, although at the time I prepared this testimony I had not seen what the proponents of these bills will present to the Committee, my client does believe it is important to point out that Kansas law requires the proponents of any mandates to provide a social and fiscal impact of the mandate. K.S.A. 40-2248. Further, Kansas statute details what must be included in the impact report. K.S.A. 40-2249. Finally, Kansas law requires what has been colloquially referred to as the "test drive" law. Any mandate that the Legislature wishes to institute must first be tried out on the state employee health plan, and the state plan would, after a year, prepare a report on the effect of the mandate on the state plan to determine if the mandate is one that should be applied to private

insurers. K.S.A. 40-2249a. We believe that it is imperative that the proponents of these bills be required to comply with these statutes.

Next, it is imperative that the Legislature keep in mind that the passage of a particular mandate will only affect approximately 30-35% of the marketplace. State law can only be applied to private insurers and not to government programs and self-insured programs. The "ERISA exception" states that federal law does not allow state laws to apply to these types of self-insured programs. That being the case, any mandate passed by the state is saddled on the private sector, increasing their costs, and providing more of a disincentive for people to buy private insurance and to look for other self-insured type program. Many of these self-insured programs do not pay premium tax, and thus these mandates can have a direct result in the lessening of premiums sold in the state and less premium tax collected.

I have attached a copy of the Resource Guide prepared by Drs. Jensen and Morrisey titled "Mandated Benefit Laws and Employer-Sponsored Health Insurance." Although lengthy, we believe that this document provides an excellent resource on many of the misnomers and problems with mandated benefits.

**H.B. 2185**

The definition of "health insurance plan" is overly broad in this particular bill. We would argue that such a proposal should not apply to individual health insurance plans inasmuch as those plans are designed for the individual and not for a broad based cross section.

**H.B. 2069**

We have major concerns about the draft language of this bill. If the Committee believes that this bill should be looked at further, I would encourage the Committee to evaluate all

the specific provisions and their applicability. For instance, we have some question as to what exactly is to be covered because much of the language in New Section 1 is not completely consistent with language found in other areas of the bill. Again, we do not believe an individual policy should be required to carry this provision.

**H.B. 2184**

We have concerns not only on the cost of the mandate in this bill, but we are uncertain as to the necessity of the additional notice requirements that are found in the bill as well. Again, we would have the same concerns relative to applying this to an individual contract.

For the above reasons, including what is incorporated in the paper by Drs. Jensen and Morrisey, we respectfully request that the Committee not act favorably on these three bills. It is our contention that the limited amount of insurance that such mandates would effect, coupled with the increased costs, dictates that passage of these mandates would be inappropriate. It is important to remember that when everything is said and done, it is the worker who pays for health insurance mandates in the form of reduced wages or fewer benefits. Mandates are not free. Thus, we believe that the Committee should act unfavorably on these bills.

We appreciate the opportunity to present this testimony, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W. Sneed

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HEALTH INSURANCE ASSOCIATION OF AMERICA

# MANDATED BENEFIT LAWS AND EMPLOYER-SPONSORED HEALTH INSURANCE

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January 1999

House Insurance
Date: 2-13-03
Attachment # 10

Washington, DC
First Edition

# 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



Illustrations





10-6

## 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.



7
10-8

## 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.

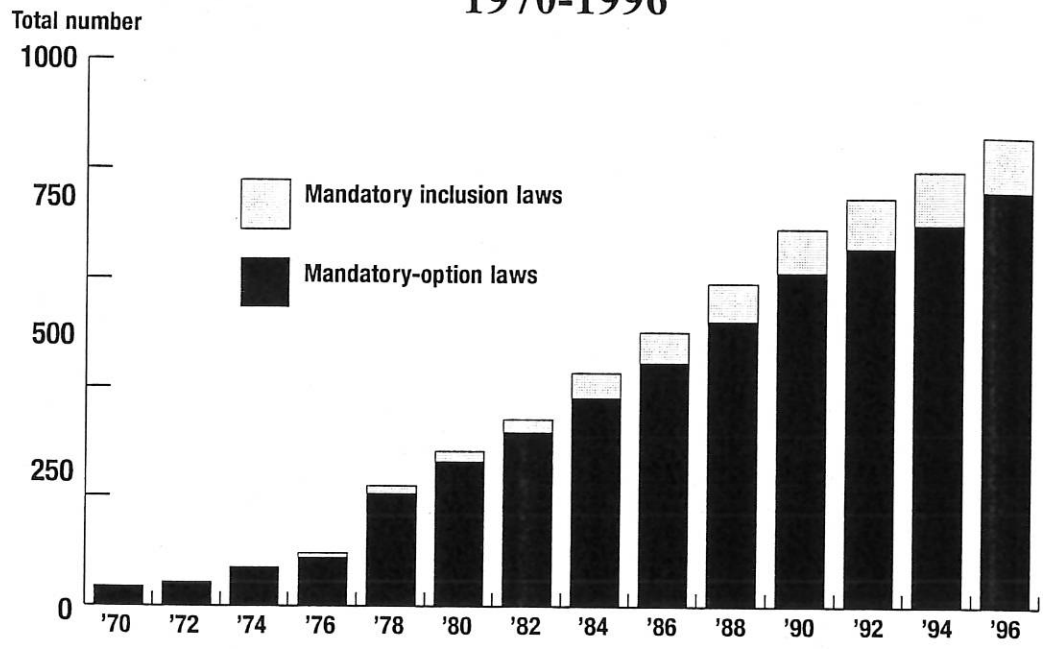
In the late 1980s and early 1990s, states began to legislate newer forms of insurance mandates, attempting to improve the small-group market by specifying particular service obligations within coverages, and delineating the nature of managed care networks.

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.

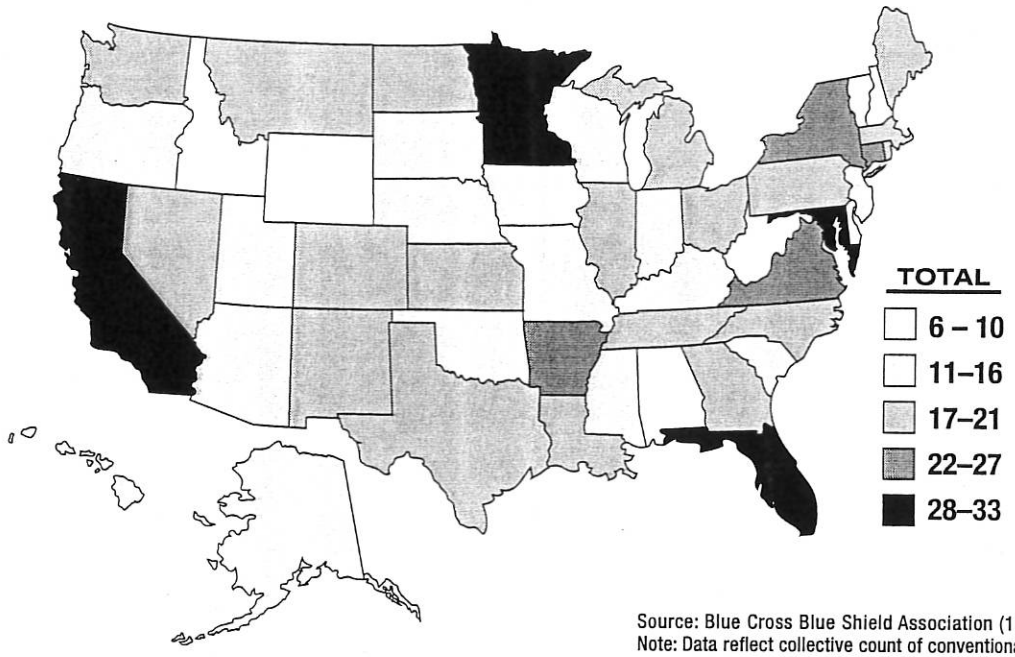
## Growth in States' Conventional Mandates, 1970-1996




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**



9
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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



10
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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.



11
12
10-14

## 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.



12
14
10-16

# 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.



13
15
10-78

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

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

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

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

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

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

# Evidence of the Effects of Mandates

## Who Is Affected by Mandates?

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

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

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

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

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

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



15
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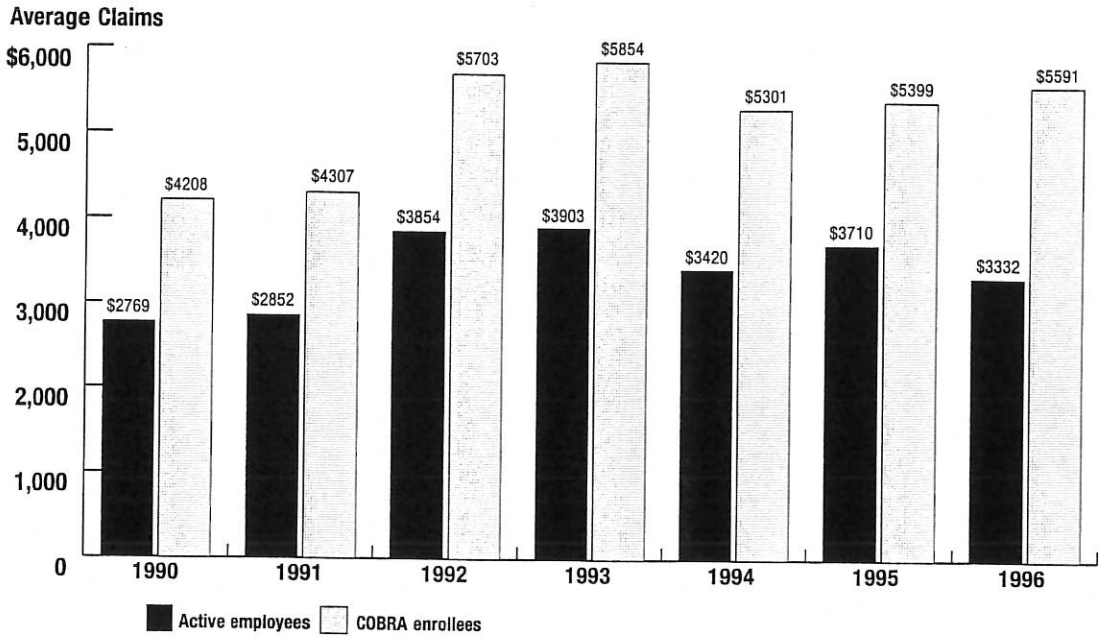
## Employers' Experiences with Adverse Selection Under COBRA, 1990–1996




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

**FIGURE 3**

### 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].



17
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10-22

## 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.



18
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10-23

## 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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24
26
10-31

# Kansas Association of Health Plans

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**Testimony before the**
**House Insurance Committee**
**HB 2069**
**February 13th, 2003**

Madam Chairman 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 other entities that are connected to managed care. KAHP members serve most all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid managed care and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on HB 2069.

The KAHP appears today in opposition to HB 2069, mandated health insurance coverage for clinical trials. We also oppose HB 2185 (mandated contraceptive coverage) and HB 2184 (mandated coverage for wigs or scalp prostheses for any person receiving cancer treatment or related therapy). We oppose all of these bills for essentially the same reason.

A couple of weeks ago you heard testimony from me and Brad Smoot on the rising cost of health care. One of the main issues covered in our testimony was the price impact mandated benefits and government regulations can have on health insurance premiums. There are many various organizations around Kansas and the nation advocating for benefit mandates. Today we are talking about three. Next week we will be talking about something else and probably something else the following week. One particular mandate may not have significant cost increases associated with it for one reason or another, however taken together benefit mandates and regulations add to the cost of health insurance premiums.

Specifically to HB 2069, many questions have been raised concerning several sections of this bill. Among our concerns: Section 1(a)(1) requires coverage for patient cost to member in a clinical trial as a result of treatment provided for a life-threatening condition. However, life-threatening condition is not defined. Sections 1(a)(3) and (4) are extremely broad and open for various interpretations. One of the main issues raised concerns New Section 1 (c) on page 2. This section is confusing to us and certainly is of concern because it appears to imply that a sponsor of a clinical trial could decide to no longer pay for a drug or device involved in a clinical trial and then the health plan would be required to pay for whatever the sponsor decides to no longer pay for. Is the intent of the proponents to shift the burden of cost of experimental treatments from the sponsor or organization performing the trial and hoping to realize a financial gain at the conclusion of the clinical trial to the private insurance industry?

House Insurance
Date: 2-13-03
Attachment # 11

However, if you go on to page 3 section 1(g)(7)(A) the definition of patient cost does not include the cost of an investigational drug or device. The bill also does not discuss the health plan's obligations for services provided outside of the plans network of providers. We are just not sure what the proponents of this bill are seeking coverage of.

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 a few years ago, requires the testing of any new mandate first on the state employees health plan in order to help determine its cost impact. That has not been done yet.

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

House Insorance Committee
2/13/03
Attachment
# 12

# KANSAS

DIVISION OF THE BUDGET
DUANE A. GOOSSEN, DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

February 13, 2003

The Honorable Patricia Barbieri-Lightner, Chairperson
House Committee on Insurance
Statehouse, Room 115-S
Topeka, Kansas 66612

Dear Representative Barbieri-Lightner:

SUBJECT: Fiscal Note for HB 2069 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2069 is respectfully submitted to your committee.

HB 2069 would require all health insurance policies, medical service plans, contracts, fraternal benefit societies, and health maintenance organizations to cover the costs associated with clinical trials, assuming the treatment is provided for a life-threatening condition or is provided for prevention, early detection, and treatment studies on cancer. Coverage would be required if the treatment being provided or the studies are being conducted in a phase I through IV clinical trial for cancer or any other life-threatening condition. Coverage would also be required if the treatment is being provided by the National Institutes of Health (NIH), an NIH cooperative or NIH center, the Food and Drug Administration as part of an investigation of a new drug, the federal Departments of Veterans Affairs and Defense, or a state institution review board that has a multiple project assurance contract approved by the NIH. The facility and personnel providing the treatment must be capable of providing such treatment. In addition, a clinical trial method would not be authorized if a proven method is available, unless data suggest that the clinical method will be at least as effective as a proven method. The bill would also require the coverage of drugs and devices that have been approved by the FDA but not necessarily approved for a patient's particular condition.

The bill would not apply to any insurance policy that provides coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital

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House Insurance
Date: 2-13-03
Attachment # 12

indemnity, long-term care insurance, vision care, or any other limited supplemental benefit. The bill would also not apply to any Medicare supplemental insurance policy, any supplemental liability insurance, workers compensation insurance, automobile medical-payment insurance, or any other insurance policy that provides benefits with or without regard to fault. Policies and plans paid for under Title XVIII or Title XIX of the Social Security Act are also exempt from this bill.

Currently, the Department of Administration offers seven employee health care plans. Five of those plans provided limited coverage for approved clinical trials. A plan's medical director must approve any treatment provided through a clinical trial. In addition, each plan identifies when clinical trials are appropriate with respect to experimental or investigational treatment, drugs, and devices. HB 2069 would require health care plans to provide coverage under broader guidelines than those currently used by individual plans. The Department estimates an increase of $1.50 to $8.90 per member per month for HMO plans during calendar year 2004. Based on 17,975 state employees (including retirees), HB 2069 would cost the state an additional $323,550 to $1,919,730 during the first year. If the 1,214 local employees enrolled in an HMO plan are included, an increase of $345,396 to $2,049,385 can be expected. Cost estimates for preferred physician organizations and managed indemnity plans have not been developed at this time, as these providers have not had any experience with this subject. A revised fiscal note may be provided should this information become available. Pharmacy benefits are estimated to cost at least $100,000 per occurrence. Any fiscal effect resulting from this bill would be in addition to the amounts included in *The FY 2004 Governor's Budget Report*.

The Insurance Department would be responsible for ensuring that all carriers include this benefit in their insurance contracts. According to the agency, this can be achieved with current staff and within existing resources.

Sincerely,

Duane A. Goossen
Director of the Budget

cc: Jerrod Forbes, Insurance Department
Pat Higgins, Dept. of Administration

# LEGISLATIVE TESTIMONY

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

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HB 2185, 2069 and 2184

February 13, 2003

House Insurance
Date: 2/13/03
Attachment # 13

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony before the House Committee on Insurance
By Terry Leatherman, Vice President – Legislative Affairs

Madam Chairperson 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 2185, 2069 and 2184. KCCI respectfully requests our comments of blanket opposition to new insurance mandates be applied to all of the bills before you today.

It is hard to find an insurance mandate initiative that lacks merit or emotional appeal. That is certainly the case with all three of the bills before you today. However, as this Committee certainly understands, if additional health insurance mandates negatively impact the cost of insurance, it will not be insurance companies who will pay these higher costs. Instead, the cost will be passed along to all Kansans who receive their insurance through policies governed by state law.

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

KCCI would also question the additional intrusion of government into the private insurance market, which would happen if additional mandates become law. Insurance is a private sector contractual

House Insurance
Date: 2-13-03
Attachment # 13

arrangement. The elements that make up an insurance product should be developed to meet the needs of consumers by insurance companies, not lawmakers.

Thank you for the opportunity to comment on the bills before you today. I would be happy to attempt to answer any questions.

**About the Kansas Chamber of Commerce and Industry**
The Kansas Chamber of Commerce and Industry (KCCI) is the leading broad-based business organization in Kansas. KCCI is dedicated to the promotion of economic growth and job creation and to the protection and support of the private competitive enterprise system.

KCCI is comprised of nearly 2,000 businesses, which includes 200 local and regional chambers of commerce and trade organizations that represent more than 161,000 business men and women. The organization represents both large and small employers in Kansas. 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.

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STATE OF KANSAS

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HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: TAXATION
TRANSPORTATION
JUDICIARY

House Insurance
Date: 2/13/03
Attachment # 14

**TESTIMONY**
**HOUSE BILL 2185**
**HOUSE INSURANCE COMMITTEE**

February 13, 2003

TO: CHAIRWOMAN PATRICIA BARBIERI-LIGHTNER AND MEMBERS OF THE HOUSE INSURANCE COMMITTEE

FROM: REPRESENTATIVE PAUL DAVIS

Madam Chair and Members of the Committee:

I appear before you today as a proponent of House Bill 2185. For many years, there has been a significant disparity in the treatment that men and women have received with regard to insurance coverage. It is estimated that women spend 68% more than men in out-of-pocket health care costs. Many of these costs are associated with contraceptives. Women have broken the glass ceiling all across the nation over the last several decades. However, the remnants of a male dominated society is reflected in the design of standard health insurance policies. For example, when Viagra was introduced in the U.S. market in 1998, more than one half of the prescriptions for Viagra received insurance coverage within the first two months. Unfortunately, we are still far away from achieving parity for contraceptives.

**Reducing Unintended Pregnancies**

Nearly half of all pregnancies in the United States are unintended, and more than half of all unintended pregnancies end in abortion. Contraceptives have a proven track record of enhancing the health of women, preventing unintended pregnancy and reducing the need for abortion. However, although contraception is part of basic health care for women, far too many insurance exclude this vital coverage.

The primary reason women take contraceptive devices is to prevent unintended

House Insurance
Date: 2-13-03
Attachment # 14

pregnancy. In any single year, 85 out of 100 sexually active women of reproductive age not using a contraceptive method become pregnant. In contrast, of 100 oral contraceptive users, only between 0.1 and 5 percent become pregnant during the first year of use. According to the Family Connection, unplanned pregnancies are frequently unhealthy pregnancies. A healthy pregnancy costs between $7,000 and $11,000. A pre-term baby can cost more than $50,000. However, the average pregnancy is about $14,000. First and second term abortions cost between $250 and $2,000. On the other hand, the average cost of oral contraceptive (birth control pills) costs around $325 per year. So over a five year period, the cost of a woman using oral contraceptives will be around $1,700. A woman who is not using contraceptives during this time period is likely to have 4.25 children at an average cost of $14,000 per pregnancy.

**Contraceptive coverage varies among insurers**

According to information gathered by the National Conference of State Legislatures (NCSL), about 93 percent of HMOs, 70 percent of point of service (POS), 50 percent of preferred provider organizations (PPO), and 50 percent of indemnity plans cover the cost of some contraception services. Many of the policies that provide contraceptive coverage do not cover all of the five most common contraceptive methods (oral contraceptives, IUD, diaphragm, Norplant and Depo Provera). And although 99 percent of people with employer-based health plans have prescription drug coverage in general, only 64 percent have coverage for oral contraceptives. This leaves more than 1/3 of the women with employer-based health plans without coverage for a prescription drug that many of them desperately need.

**Why is Coverage Important?**

According to a recent poll commissioned by the Kaiser Family Foundation, 3 in 4 adult women say cost is an important factor when choosing between a method that is covered and one that is not. Therefore, many women may not choose the method that is most appropriate for them. For example, the IUD and Norplant have up-front costs that can be prohibitive for women who do not have some discretionary income, but they are among the most effective of all methods. Additionally, many women who are strapped for cash may wait to fill a prescription for oral contraceptives or get a Depo Provera shot. This happens and has serious consequences. One half of the unintended pregnancies in the United States are to women who are "using" contraception.

**Employer Cost Issues**

In 1998, Congress enacted legislation requiring the Federal Employee Health Benefits Program to cover all FDA-approved prescription contraceptives. Three years later, the Office of Personnel Management for the federal government reported that "there was no cost increase due to contraceptive coverage" in the plan. The Washington Business Group on Health estimates that not covering contraceptives in employee health plans would cost 15 to 17 percent more than providing the coverage. They stated that "providing contraceptive coverage would reduce employers' direct and indirect unintended pregnancy costs including: expenditures for normal live births, abortions, miscarriages, ectopic pregnancies, wages and benefits for employee

absences, maternity leave, pregnancy-related sick leave, replacing employees who do not return after a pregnancy as well as the costs of reduced productivity during an employee's pregnancy." In a study published by the *American Journal of Public Health* about the costs and benefits of contraceptive coverage in managed care plans provided by large employers in 45 major metropolitan areas, it was found that all 15 contraceptive methods were cost-effective compared with direct medical costs of unintended pregnancies that would otherwise occur, with savings ranging from $9,000 to $14,000 over a five year period.

According to the Alan Guttmacher Institute, providing coverage for the full range of contraceptive methods would result in a total cost of $21.40 per employee per year. Assuming standard cost sharing between employers and employees, the employer would pay $17.12, which translates into a monthly cost of $1.43 per employee. This would increase employers' overall insurance costs by only 0.6 percent but does not take into consideration the cost savings that will result down the road by having fewer unintended pregnancies.

**A suggested amendment**

Several years ago, the Legislature passed a "test track" bill that would require any new insurance mandate that is enacted to be "tested" on the state employee health plan for a period of two years and then revisited by the Legislature before the mandate could take effect. The current state employee health plan covers contraceptive devices. There are a couple of FDA approved devices that are not covered, but if they were covered, the cost would be negligible. Therefore, I would recommend that if the committee chooses to favorably recommend this bill, an amendment be added to the bill that would exempt the bill from the test track provision.

At last count, over 20 states have passed legislation requiring insurance companies and health plans to provide comprehensive contraception coverage. According to a recent Kaiser Family Foundation poll, America's public overwhelmingly supports mandating contraceptive coverage. 78 percent of privately insured adults supports contraceptive coverage, even if it were to mean that their insurance costs would increase by as much as $5 per month. 71 percent of those surveyed believe that the requirement should include coverage for all FDA-approved methods.

I urge your favorable consideration of House Bill 2185 and I thank you for allowing me to present this testimony.

# The Need for and Cost of Mandating Private Insurance Coverage of Contraception

by Rachel Benson Gold

With the issue of contraceptive coverage rapidly gaining public attention and political momentum, a central question is whether a government mandate on private, employment-related insurance coverage would constitute good public policy. The question largely boils down to whether a mandate, in this instance, is necessary to achieve an important public interest and whether it is justified in light of its fiscal impact on employers and employees.

Industry representatives oppose mandates in general, charging that they are unnecessary and serve mostly to drive up the costs of insurance coverage. Women's health advocates, on the other hand, argue that, whether from benign neglect or outright discrimination, women traditionally have been disadvantaged in insurance coverage. They point to past examples where government mandates were necessary to secure coverage even of women's most basic health care needs and argue that similar action is required and appropriate now with regard to contraception.

## Women and Insurance

As their most striking example of historic discrimination against women in insurance coverage, advocates cite maternity care—basic prenatal and delivery services—which, until the late 1970s, private insurance plans in the United States often did not cover. Indeed, it took enactment of a federal law—the Pregnancy Discrimination Act of 1978 (PDA), which mandates maternity coverage in most private-sector policies—to change the situation. And change the situation it did: Coverage for maternity care jumped from 57% of policies written in 1977 to 89% of policies just five years later.

While the PDA undeniably played a major role in ending de facto insurance discrimination against women, advocates argue that the job is not done. Even now, according to the Women's Research and Education Institute, women of childbearing age spend 68% more in out-of-pocket health care costs than do men of the same age. Contraception, advocates contend, is now in the same position maternity care was just 20 years ago—which is to say, it is basic health care for women that private insurance fails to adequately cover.

## Gaps in Contraceptive Coverage

If a sexually active woman between ages 20 and 45 wants—as do most American women—two children, she will spend, on average, almost five years of her life trying to become pregnant, or being pregnant or postpartum, and more than *four times that long* trying to avoid pregnancy.

Overwhelmingly, American women use contraception to avoid unintended pregnancy. Among women aged 20–44 who have ever been sexually active, for instance, 85% have used oral contraceptives at some point in their lives. Among women with some form of private health insurance coverage who are at risk for unintended pregnancy, only 7% use no method of contraception.

Although American women clearly view contraception as basic to their lives, and their health care, health insurers in this country traditionally have not. While three-fourths of American women of childbearing age rely on private insurance, the extent to which they are covered for contraception can differ dramatically depending on their type of insurance,

## *A Note from the Editor*

*After simmering slowly for a number of years, the effort to ensure comprehensive coverage of contraceptive services and supplies in private-sector, employment-related group health insurance plans has exploded. This year alone, nearly 20 states have addressed the issue—including Maryland, which enacted the first statewide coverage mandate this spring. For its part, Congress is on the verge of setting an important precedent for its own consideration of a federal mandate and, at the same time, an example for employers across the country: Last month, both houses passed bills requiring contraceptive coverage in the health insurance plans made available to federal employees (see* For The Record, *page 12). With momentum building, the contraceptive coverage debate is crystallizing around three key questions: the need for and cost of a government mandate; the appropriate scope of any exemption to a mandate that would be granted on grounds of conscience; and the methods that should be included in a mandate, specifically in terms of what constitutes "contraception" and what constitutes "abortion."*

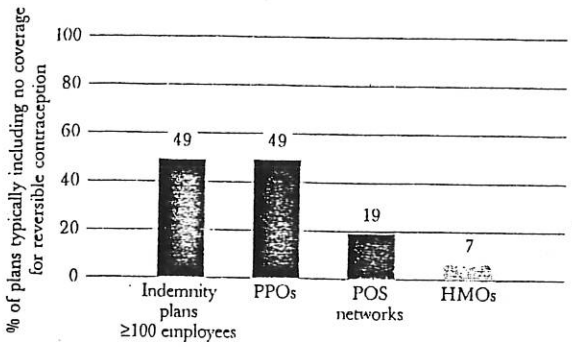
*Beginning with this issue,* The Guttmacher Report on Public Policy *will examine these questions in a special series of articles supported in part by a grant from the Prospect Hill Foundation. The conclusions and opinions expressed in these analyses are those of the authors and The Alan Guttmacher Institute and do not necessarily represent the views of the foundation.*



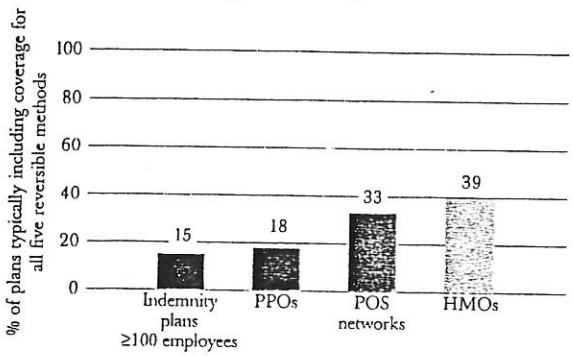
14-4

## Inadequate Coverage

*Many plans cover no contraception at all*




*Few plans cover the five leading reversible methods**




*Oral contraceptives, IUD, Norplant®, Depo Provera®, diaphragm.

according to a 1994 study by The Alan Guttmacher Institute (AGI).

Traditional indemnity (fee-for-service) plans—which cover one in five privately insured Americans (18%), according to KPMG Peat Marwick—clearly provide the least comprehensive coverage for contraceptive services and supplies (see chart). Half of these policies typically cover none of the five leading reversible prescription contraceptive methods (IUD, diaphragm, hormonal implant [Norplant®], contraceptive injectable [Depo Provera®] and oral contraceptives), and only 15% cover all five methods. While 97% of indemnity plans cover prescription drugs in general, only 33% cover the costs of oral contraceptives, the most commonly used reversible contraceptive method in the United States.

Health maintenance organizations (HMOs), which cover one-third of the market (33%), provide the most comprehensive contraceptive coverage of any type of insurance plan: Some 39% cover all five leading methods, and only 7% cover no contraception at all.

Newer types of managed care plans—which serve half the U.S. market—provide less extensive coverage than do HMOs. Preferred provider organizations (PPOs)—which cover almost as many Americans as do HMOs (31% of the market)—are closer to traditional indemnity plans in their coverage patterns; coverage in point of service (POS) networks is somewhat more comprehensive.

In sharp contrast, almost nine in 10 plans, regardless of plan type, cover sterilization services. And, about two-thirds routinely cover abortion.

### Why Coverage is Important

According to a recent poll commissioned by the Kaiser Family Foundation (KFF), three in four adult women say cost is an important factor when choosing between a method that is covered and one that is not. In the absence of comprehensive coverage, many women may "choose" a method covered by their plan rather than one that might be more appropriate to their medical or life circumstances. The impact could be significant. Some methods, like the IUD and the contraceptive implant, Norplant®, have up-front costs that can be prohibitive for women without significant discretionary income; at the same time, they are among the most effective of all methods.

Similarly, cost concerns may affect how well women are able to use their chosen method. Some women may delay refilling a prescription for oral contraceptives, for example, or put off obtaining a Depo Provera® injection because of cash-flow problems. And even a brief gap in method use can have a major impact. Notably, half of the unintended pregnancies in the United States are to women who are "using" contraception—but not always consistently or with maximum effectiveness.

Most dramatically, in the absence of insurance coverage some few women may forego contraceptive use entirely—and a sexually active woman not using contraception is many times more likely to become pregnant unintentionally than a woman who is. In any single year, 85 of 100 sexually active women not using a contraceptive method will become pregnant, in contrast to less than one-tenth that many of every 100 oral contraceptive users.

### How Much Would It Cost?

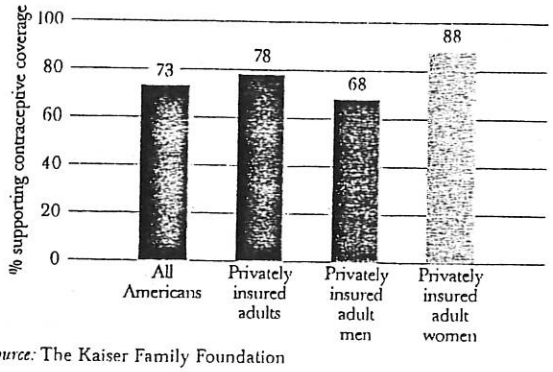
Central to any discussion of an insurance mandate is the question of its cost—specifically, whether the mandate will drive up the cost of insurance so much that coverage will become prohibitively expensive to some employers and their employees will suffer as a result.

New AGI estimates—based on the actual experience of plans that cover the cost of oral contraceptives (information obtained from pharmacy benefit managers administering plans covering over half the U.S. population) and on national data on use of other methods by privately insured women—show that the cost of covering the full range of FDA-approved reversible contraceptive methods is minimal. (The estimate does not include the costs of any associated medical services.)

Providing coverage for the full range of reversible contraceptive methods would result in a total cost of $21.40 per employee per year. Assuming standard cost-sharing between employers and employees, employers would pay $17.12, which translates into a monthly cost of $1.43 per employee. This would increase employers' overall insurance costs by only 0.6%. Employees would contribute $4.28 per year, or $0.36 per month.

## WIDESPREAD SUPPORT

***Americans overwhelmingly support contraceptive coverage, even if it would increase their insurance costs by $5 a month***




*Source:* The Kaiser Family Foundation

As minimal as these costs are, they would only be borne in their entirety by a plan that does not now cover any of these reversible methods. The cost would be less for those plans that cover at least some of these methods, and there would be *no* added costs for the many plans that currently cover the full range of FDA-approved reversible contraceptive methods.

### Support for Contraceptive Coverage

According to the recent KFF poll, America's public overwhelmingly supports mandating contraceptive insurance coverage (see chart). Eight in 10 privately insured adults (78%), support contraceptive coverage, even if it were to mean that their insurance costs would increase by as much as $5 a month—almost 14 times the actual cost to individuals of a contraceptive coverage mandate. Support for contraceptive coverage rises to 88% among privately insured women.

In addition, seven in 10 privately insured Americans (71%)—and eight in 10 insured women (79%)—believe that a mandate should require coverage of all FDA-approved contraceptive methods.

### Industry Perspectives

As noted, the U.S. insurance industry opposes governmental mandates across-the-board on philosophical grounds. At the same time, it fights harder against some than others. The industry is now considering its options amid clear signs that the contraceptive coverage issue is resonating among the public and politicians alike—and that the costs of a mandate are minimal.

In that light, many observers found it significant that, even as Congress was moving last month to mandate contraceptive coverage for federal employees, the Health Insurance Association of America (HIAA) declined an invitation to present its position at a Senate hearing on the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC). Authored by Sens. Olympia Snowe (R-ME) and Harry Reid (D-NV), EPICC would require coverage nationwide in private, employment-related plans. Instead, HIAA President Willis Gradison (himself a former Member of Congress) was quoted by *Washington Post* reporter and syndicated columnist David Broder as saying, "We oppose mandates, but we're not going to spend a dime fighting this."



14-6