LAWS AND CONSEQUENCES:

AN EXAMINATION OF CERTAIN ECONOMIC, MEDICAL, AND POLICY IMPACTS OF MANDATED HEALTH CARE BENEFITS

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The Vermont Business Roundtable is a non-profit, non-partisan organization of 115 chief executive officers representing geographic diversity and all major sectors of the Vermont economy. The Roundtable is committed to sustaining a sound economy and preserving Vermont's unique quality of life by studying and making recommendations on statewide public policy issues.

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INTRODUCTION

In Vermont as well as the nation, policy-makers and health care professionals continue to struggle with three difficult and at times conflicting objectives: (1) controlling health care costs; (2) maintaining optimum physical and financial access; and (3) delivering the world's highest quality health care as measured across three dimensions: patient satisfaction, outcomes of the treatments given, and improving the overall health of the population.

The growth of "managed care" in Vermont and across the nation has been one market response to concerns about double-digit health care cost inflation. But as managed care has evolved, it has generated public worries about access to care and whether quality is compromised by managed care companies' attempts to contain costs and rationalize the delivery system. Reacting to public alarm, legislatures across the nation have turned to "mandated benefits" as one form of protection.

During its 1997 session, the Vermont legislature considered 19 separate "mandated benefits" bills and ultimately passed several of them into law.[1] During that session, members of the Vermont Business Roundtable[2] began to express increasing concern about the economic, medical, and other potential impacts of the unusually high level of benefits-related legislation.

Clearly there is an important role for legislative oversight of the private health insurance market. However, it is also critically important that Legislators fully understand the economic, competitive, and other consequences of benefit mandates on companies trying to do business in Vermont. Furthermore, mandates per se may or may not be the most efficient way to accomplish legislative intent.

In the summer of 1997 the Roundtable conducted a comprehensive survey of its 100+ member companies to gather both hard data and business leaders' attitudes on the cost of doing business in Vermont, on fringe benefit costs including health insurance; mandates; and related subjects.

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[1]See Appendix 1, listing of 1997 Vermont Legislative Bills, prepared by Blue Cross Blue Shield of Vt.

[2]The Roundtable is made up of the CEOs of 115 leading Vermont companies, employing 40,000 people. It is a non-profit, non-partisan organization whose work is funded by its member companies.

Using that data, the Roundtable leadership commissioned its Health Care Task Force to prepare this "white paper," which would incorporate the survey findings and other research on the subject of mandated benefits.

The purpose of the paper is to briefly explore the reasons for benefit mandates, to discuss some possible unintended consequences when mandates are enacted, and to share research on mandates that policy-makers may find useful. Clearly, the Legislature needs an effective means to assess the costs and benefits of the many proposals for mandates that come before it each year, in order to separate the merely more expensive from the truly beneficial. Other states face this problem and have found useful solutions which are discussed herein. This paper does not take a position pro or con on any specific mandates. Rather, its purpose is to illuminate the dialogue around a subject that has significant consequences for the fiscal as well as physical health of all Vermonters.

MANDATES ARE POPULAR

Over the past 20 years, more than 1100 state laws have been enacted across the U.S. that mandate specific benefits or coverages in health insurance contracts.[3] Generally these so-called "mandated benefits" fall into three categories: (1) those that expand the kinds of services covered (e.g., alcoholism treatment), (2) those that expand the types of providers eligible for payment (e.g., chiropractors), and (3) those that expand the categories of people eligible to receive benefits under a contract (e.g., dependents beyond x age, same-sex couples, etc.).

Understandably, mandated benefits historically have received wide popular support. Typically, proponents include patients or patient advocates who benefit from the expansion of coverage for a particular service; health care providers who may receive significant increases in patient revenues; and State legislators seeking to respond to concerned constituents without spending scarce tax dollars.

The media often adds emotional charge to the debate with stories about patients thrown out of the hospital because insurance benefits run out or are denied; patients not covered for exotic, expensive but potentially life-saving treatments because insurers deem them "experimental," and stories about providers of health care who are being increasingly challenged by cost-conscious insurance companies.

Further, the American public has been conditioned to believe that unlimited access to what is generally perceived as the best health care system in the world is a "basic right," and that our doctors and hospitals, given unlimited funding, can cure almost any health problem we develop or incur. Therefore, there is strong popular support for increased access to health care at "no cost" or limited cost; conversely, any attempt to limit access is politically disfavored. These popular undercurrents may partially explain the epidemic of "anti-managed care" legislation that

[3] See Appendix 2 for a comprehensive listing by state of recent mandated benefits legislation.

is presently sweeping the State and national legislatures.

However, medical professionals and economists have long understood that demand for health care is unlimited (particularly if it is covered by insurance) and that health care costs, unless somehow contained, will continue to rise at a rate that is ultimately unsustainable. Therefore when any policymaking body takes actions that will demonstrably affect access to health care, it should be understood that there will be significant cost impacts on those who pay for health insurance, and perhaps unintended consequences on the quality of health care itself.. Therefore, such action should be taken only after best efforts to fully research the resulting consequences.

MANDATES, ECONOMICS AND UNINTENDED CONSEQUENCES

Proponents of benefit mandates typically argue that the cost of a specific mandate is not great, or that mandates will save money over the long run by reducing the need for more expensive services. Provider proponents often argue that improved access to their specific services will generally improve public health, or that "preventive" mandates will prohibit insurance companies from taking actions in the name of cost control that might harm or inconvenience some patients.

On the other hand, numerous economic studies done over time do not necessarily support, and in many cases contradict, these arguments.[4]

- While the cost effects of a single benefit mandate may not be high, the cumulative effects of multiple mandates can be costly indeed. A 1992 study of Blue Cross Blue Shield Plans in 13 states found that claims payment costs (reflected in premiums) rose between 5% and 21% that year alone as a result of benefit mandates. In Vermont, estimates of the increased costs of mental health benefit mandates passed in 1997 range from 3% to 5% of total premiums.[5]

- Mandates may not result in substituting one treatment for another, or less costly treatment for more costly treatment. Studies in Maryland, for example, revealed that outpatient mental health visits rose dramatically after coverage was mandated, from 448,000 statewide in 1983

[4] See Bibliography, notation 4.

[5] 1997 Legislative Testimony, Blue Cross Blue Shield of Vt., Vermont Employers Health Alliance, Coopers/Lybrand Study. Also see Employee Benefit Research Institute Brief, February 1997.

to 800,000 per year in 1986.[6] The most likely result of mandates is an increase in health care utilization and health care costs. Presumably there should be a commensurate improvement in public health, but studies to demonstrate such improvement are much harder to find. Since even proponents generally agree that mandated increases in health insurance coverage increases costs, presumably the Legislature understands that and has judged that the benefits of mandates are worth the price. However, mandates also may trigger a series of less obvious impacts that may not be as well understood by policymakers, but are of serious concern to businesses in Vermont. For example:

[6]Mary Nell Lehnhard, Blue Cross Blue Shield Association Testimony before U.S. House of Representatives, 7/29/91.

- Vermont is generally perceived by employers as a costly place to do business. The Roundtable survey[7] results show that more than 66% of employers believe it is more expensive to conduct business in Vermont than elsewhere in New England (only 4% believe the cost to be lower).

  Two out of three respondents say that fringe benefit costs are a "significant" or "very significant" cost of doing business. Vermont generally has difficulty competing with other States to attract and retain the kind of businesses with high-paying, quality jobs that are essential to its economic well-being. We should therefore think very carefully about anything that worsens our competitive disadvantage for jobs, including health insurance benefit mandates.

  In the Roundtable survey, 24% of respondents said a "significant" increase in fringe costs could negatively affect their decision to move business into Vermont, 66% said they might decide not to expand in Vermont, and 17% said they might not be able to stay in business at all.

- Employers generally do not absorb the higher health benefit costs resulting from mandates; rather, they find ways to avoid such costs altogether or pass them along to the employees.

  One Roundtable CEO commented "I prefer to think of employee benefit programs as indirect pay. Since the market will support only a certain level of total labor cost, employees have to choose to be paid in insurance benefits or dollars."

  The most common responses to rising cost are (1) to increase the amount of total health insurance cost deducted from employees' paychecks, (2) increase the deductibles and co-pays, or (3) go self-insured and avoid State mandates altogether. The Roundtable survey found that in response to rising health insurance costs over the past five years nearly one-half of its member companies have increased co-pays charged to employees, one-third have increased deductibles, and nearly 20% have cut costs by self-insuring and thus avoiding mandates. One company dropped health insurance altogether.

- Self-insurance, and thus avoidance of most State regulation including mandates, is by far the most rapidly increasing business response to higher insurance cost. The Roundtable survey showed that 54% of its member companies are now self-insured; this number is comparable to national statistics which show that well over half of all employers' health plans are self-funded and thus are exempt from state mandates.

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[7] See Appendix 4 for pertinent excerpts from the Roundtable Survey.

The tendency to self-insure is much greater among larger, ERISA exempt employers (those with more than 100 employees), where nationally nearly 75% are self-insured. (In addition to escaping mandates, these companies also avoid State premium taxes, assessments on insurers, health insurance access and renewability requirements, and other laws designed to protect the rights of policyholders.)

Ironically, the burden of mandates therefore falls disproportionately on small employers which are so important to the Vermont economy, worsening their competitive disadvantage, and on their employees, who already are the most vulnerable in today's insurance market. It also means that mandates actually affect less than half of those covered by private health insurance, driving up costs for those least able to afford it. To the extent that mandates increase employers' interest in self-insurance, the proportion of employees not covered by mandates will continue to rise.

- As noted above at least some companies respond to mandates by dropping health insurance altogether. A 1992 study reported in the *Journal of Public Economics* estimated that mandated benefits prevented one in five small firms that do not offer health insurance to their employers from doing so.[8] Thus mandates potentially harm public health by restricting access to care.

- Mandates also tend to increase the numbers of uninsured by preventing carriers from offering affordable, basic benefit packages that would at least protect against catastrophic health care costs. As early as 1988, an econometric study by the National Center for Policy Analysis concluded that 14-25% of the uninsured population are unable to buy insurance due to the cost of mandates.[9] Since that time States have passed more than 300 new mandated benefit laws, presumably exacerbating that problem.

- Finally, mandates appear to worsen the uninsured worker problem. A recent study by Project Hope, a Washington, D.C., health education foundation, found that six million workers who could have been covered by job related health insurance turned it down. The majority (4.6 million) of those rejecting coverage chose to remain uninsured. "Workers are deciding that health insurance is not worth the cost" says Barbara Schone, the study's co-author and economist at the Agency for Health Care Policy and Research. As mandated benefits continue to drive up the cost of health insurance, employees' temptation to go uninsured will continue to rise.

MORE UNINTENDED CONSEQUENCES

[8] See Bibliography, notation 4.

[9] See Bibliography, notation 4.

In addition to these largely economic consequences of mandates, they can have significant and unintended effects on public health and the health care delivery system itself. For example:

- If mandates drive up the cost of health insurance coverage and increase the number of uninsured, either access to health care is reduced, or providers will encounter higher and higher charity care costs, negatively affecting their bottom lines and possibly the quality of care.

- Increased numbers of uninsured people place greater burdens on State-run tax-supported programs such as Medicaid, Doctor Dynasaur, etc. Generally these programs reimburse providers of care at levels considerably below their costs, which ultimately could negatively affect quality of patient care, teaching and research programs, and so on.

- Numerous and well-documented studies have shown that the demand for medical care is virtually insatiable, when care is "free," that is, paid for by an insurance company. Mandates tend to induce demand, which tends to increase the numbers of providers of care, thus encouraging both unnecessary treatment and the proliferation of marginal providers who might not survive if normal supply and demand economics were at work.

- Mandates also tend to interfere with a rather delicate system of checks and balances that has developed over time in the health care delivery and financing system. Two examples of that are: (1) the effects of length of stay mandates for certain hospitalizations and (2) mandated coverage of experimental treatments. These examples deserve brief exploration:

  There has been a recent public outcry over so-called "drive through mastectomies," resulting in a spate of proposed or enacted state and federal laws requiring minimum hospital stays following partial or total breast removals. On the face of it, this kind of mandate seems perfectly designed to protect the public health against excessive "managed care" cost containment efforts. However, a recent white paper released by the National Council on Medical Management[10] indicates that early discharge may sometimes be preferred purely for health related reasons.

  This paper summarizes three studies showing that as early as mid-1980 some surgeons began performing mastectomies with one-day (no overnight) stays, and that by 1995 almost 8% of the 110,000 mastectomies paid for by Medicare were done outpatient. Surgeons preferring the outpatient setting cited fewer infections, faster healing, the psychological and emotional benefits of recuperating at home in a familiar setting, and of course reduced cost.

[10] See Bibliography, notation 10.

Significantly, the medical outcome studies found that medical complications from out-patient mastectomies were comparable to and in some cases lower than those done inpatient. All the studies reported high levels of patient satisfaction. The studies did NOT indicate that all or even a significant percentage of mastectomies should be done outpatient. Rather the finding was that such decisions should be made by medical professionals on a case-by-case basis driven by medical indications as to what is best for the patient.

Mandates also can lead to coverage of medical procedures or technologies that are very expensive, not demonstrably effective and possibly even harmful to patients. Most insurers will not pay for experimental or investigative procedures, because they are scientifically proven to be effective.

However, the simultaneous rise of managed care plans, which tend to reduce availability of money to subsidize research, and a continuing reduction in governmental funding, has caused some providers to look increasingly to third-party payers as funding sources. Thus a few states have enacted provider-driven mandates to cover experimental or investigational procedures, in effect obviating or bypassing the traditional disciplines. At the very least this raises the issue of whether sound public policy should permit substituting a political process for sound medical research.

IS THERE A BETTER WAY?

As experience with mandates has become better documented, policymakers are becoming aware of the potential negative effects of their unchecked proliferation. Thus 17 states enacted mandated benefit evaluation laws between 1984 and 1992, and several others have since followed suit, although not all the states with evaluation laws are yet effectively using them. This legislation generally requires that independent financial impact studies on each proposed mandate be submitted to the legislature prior to final action. The State of Washington passed the first such law in 1984[11], one that sets forth a series of questions intended to measure the financial

[11] West's Revised Code of Washington Annotated Title 48. Insurance Chapter 48.47. Mandated Health Benefits: 48.47.010. Definitions; 48.47.020. Submission of mandated health benefit proposal--Review--Benefit must be authorized by law; 48.47.030. Mandated health benefit proposal--Guidelines for assessing impact--Inclusion of ad hoc review panels--Health care authority; and 48.47.900. Severability--1997 c 412.

consequences and social effects of any proposed benefit mandate. This law has become the prototype for many other states, although a few (e.g., Maine and Pennsylvania) have passed more complex versions requiring more detailed evaluation criteria. Typically these laws ask how many persons would benefit from a mandate, the cost impact of the mandate on purchasers and consumers, the effect on access to coverage for those who lack insurance, and so on.

An example of tougher laws is a bill pending in Maryland (HB 668) that would create a joint legislative committee charged with (1) assessing financial and socioeconomic impacts of proposed mandated benefits, (2) determining the premium costs of an approved standard benefit package as a percentage of the state's average annual wage, and (3) determining the portion of this premium attributable to benefit mandates.

Finally, the American Legislative Exchange Council (ALEC) is supporting a "Mandated Benefits Review Model Act"[12] that sets forth recommended content of mandate evaluation laws.

A recent survey[13] of the states with such laws shows that indeed they significantly curtail the numbers of mandates when the process is followed, but some mandates do withstand scrutiny and are enacted into law. Such an evaluation process, which typically is carried out by state insurance departments and reported to appropriate committees of the legislature, might be particularly useful in Vermont, where typically the Legislature is thinly staffed and poorly supported financially.

Vermont does have, however, both in its state university and several excellent private colleges, programs in business and public management with substantial evaluative and advisory resources. Policymakers should consider routinely using these resources as part of the evaluative process on any proposed legislation that appears to have significant economic or social impact.

A recent *Burlington Free Press* editorial entitled "Better Health Care" points to another alternative to piecemeal mandates:

> "Lawmakers have attempted to mandate, body-part by body-part, what insurers cover. This drives up costs, creating more uninsured people. It also forces people to buy more coverage than they might want. A more thoughtful approach would define the basic benefits that each plan must offer, so every ... customer can be confident of receiving proper care." Further, too often people receive or are denied unproven treatments based on how much bad publicity an insurer can withstand. A balanced discussion on experimental care, focusing on patient health, would create a medical basis for these decisions instead."

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[12]See Appendix 4 for details of the Model Act taken from Sourcebook of American State Legislation, 1995, Volume II.

[13]Survey of Blue Cross Blue Shield Plans in 17 states, conducted by Blue Cross Blue Shield Association, Washington D.C.

While the *Free Press* editorial does not suggest how these ideas might be implemented, they do deserve serious consideration as alternate means of implementing public policy.

Finally, lawmakers might benefit from the experience of other states, where their counterparts have concluded there is not necessarily a direct connection between unlimited access to health care and better quality of health care outcomes. The Oregon experience offers perhaps the leading body of literature in that respect. Policymakers there have established limits on access to various forms of medical treatment based on limits in available funding. There is no compelling evidence to date that the public health has been seriously compromised.

SUMMARY AND CONCLUSION

In conclusion, mandated benefits arise from an understandable desire on the part of duly elected policymakers to intervene in perceived problems with our complex health care delivery and financing system. The case for mandates has been and will continue to be strongly built by various advocates, often aided by sensational media coverage.

This paper has pointed out some drawbacks, for example: (1) mandates fail to reach more than half of the privately insured Vermonters that they intend to help; (2) they reduce choice and increase costs to consumers; (3) mandates negatively impact the ability of Vermont employers to compete and thus to create and maintain good jobs; (4) mandates increase the numbers of uninsured and drive up cost of publicly supported programs; and (5) they potentially compromise access to quality health care in the State. Further, it sets forth Vermont Business Roundtable research findings from other states facing similar problems that might be useful to our policymakers.

The intent of the paper has been to facilitate a more informed dialogue as to whether there is a more efficient and less potentially damaging way to implement important public policy in this complex and sensitive public policy arena.

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Appendix 1
1997 VERMONT LEGISLATIVE BILLS

House

H.16 Introduced by Representative Keenan of St. Albans City
This bill proposes to require that health insurers provide coverage for bone density screening for osteoporosis for women.

H.18 Introduced by Representative Keenan of St. Albans City
This bill proposes to require that health insurers provide hospitalization coverage for a minimum of 48 hours for vaginal deliveries and a minimum of 96 hours for caesarian deliveries.

H.57 Introduced by Representative Poirier of Barre City and others
This bill proposes to prohibit discrimination by health insurance companies in the treatment of mental health and substance abuse disorders.

H.74 Introduced by Representative Alfano of Calais
This bill proposes to prohibit managed care organizations from offering financial incentives to health care providers.

H.77 Introduced by Representative Alfano of Calais
This bill proposes to permit health care providers within a managed care system to advocate for health care options for their patients.

H.88 Introduced by Representative Milkey of Brattleboro and others
This bill proposes to require health insurers to provide consumers access to medically necessary treatment in a timely manner, and to establish judicial remedies for violations of the statute.

H.90 Introduced by Representative Little of Shelburne and others
This bill proposes to consolidate and strengthen privacy and confidentiality safeguards for individually-identifiable health care information.

H.109 Introduced by Representative Corren of Burlington and others
This bill proposes to allow a patient who is expected to die within a year to end his or her life in a humane and dignified manner by prescription medication.

H.118 Introduced by Representative Paquin of Fairfax
This bill proposes to open the Vermont Health Access Program to Medicare recipients on the same basis it is open to other Vermonters.

H.119 Introduced by Representative Poirier of Barre City
This bill proposes to require health insurers to pay for medically necessary prescription drugs, even if the prescribed drug is not included on the health insurer's formulary, and to require health insurers to disclose to consumers annually information related to restricted formularies.

H.132 Introduced by Representative Dunne of Hartland and others
This bill proposes to authorize transient practice of dentistry and medicine within Vermont by persons licensed in another state for not more than 10 days in a calendar year provided such practice is on a voluntary basis or for educational purposes.

H.140 Introduced by Representative Valsangiacomo of Barre City
This bill proposes to insure that any child will continue to be covered under a family's health insurance policy while the child lives in the family home and remains unmarried.

H.148 Introduced by Representative Alfano of Calais
This bill proposes to create the Vermont Consumer Health Care Association to represent the interests of consumers who are members of the association.

H.163 Introduced by Representative Kehler of Pomfret
This bill proposes to authorize the public counsel for health insurance to represent the interests of health insurance consumers in Vermont.

H.167 Introduced by Representative Valsangiacomo of Barre City et al.

This bill proposes to provide incentives for insurance companies to pay claims in a timely manner.

H.172 Introduced by Representative Valsangiacomo of Barre City et al.
This bill proposes to require public notice and an opportunity for hearing prior to approval of increased premiums for Medicare supplemental insurance policies, to require community rating of individual and group Medicare supplemental insurance policies, and to prohibit the cancellation of health benefit plans when the insured individual reaches the age of 65.

H.191 Introduced by Representative Dunne of Hartland and others
This bill proposes to restrict the use of genetic testing for employment, membership in a labor organization, professional licensing or insurability, and to provide safeguards for confidentiality of genetic testing information.

H.196 Introduced by Representative Kurt of Colchester and others
This bill proposes to require that manufacturers of pharmaceuticals offer the same discount to all purchasers.

H.225 Introduced by Representative Pugh of South Burlington
This bill proposes to require health insurance plans to offer a point-of-service plan, so that enrollees can have an option to choose their health care provider.

H.233 Introduced by Representative Alfano of Calais
This bill proposes to direct BISHCA and the department of liquor control to study the feasibility of creating a wholesale drug outlet, and to authorize a department to apply for a license as a wholesale drug outlet or wholesale drug distributor.

H.241 Introduced by Representative Pugh of South Burlington
This bill proposes to require health insurance plans to provide coverage for medically necessary obstetrical and gynecological health care.

H.255 Introduced by Representative Kitzmiller of Montpelier et al
This bill would require health insurers to provide coverage for medically necessary care and treatment of cancer.

H.257 Introduced by Representative Bouricius of Burlington and others
This bill proposes to require that meetings of boards of directors of nonprofit hospitals be subject to the open meeting laws.

H.265 Introduced by Representative Casavant of Winooski and others
This bill proposes to require health insurers to provide coverage for prescribed self-management training, equipment, and supplies for the treatment of diabetes.

H.272 Introduced by Representative Poirier of Barre City
This bill proposes to establish standards and procedures for the coverage of medically necessary treatment.

H.274 Introduced by Representative Casavant of Winooski and others
This bill proposes to require health insurance plans to cover treatment of craniofacial disorders.

H.304 Introduced by Representative Howard of Rutland Town
This bill proposes to require insurance companies to develop plans for investing a portion of their assets in the Vermont business and cultural community.

H.306 Introduced by Representatives Keenan of St. Albans City and Buchdahl of Georgia
This bill proposes to require health insurers to provide medically necessary emergency medical services.

H.313 Introduced by Representative Murphy of Ludlow
This bill proposes to require payment of reasonable attorney's fees for an insured or beneficiary who prevails in a legal claim against an insurance company.

H.328 Introduced by Representative Paquin of Fairfax
This bill proposes to expand the physical therapy practice act to include physical therapy aides and other assistive personnel.

H.349 Introduced by Representative Emmons of Springfield
This bill proposes to expand the scope of the practice of podiatry to include diagnosis and treatment of ailments of the lower leg.

H.355 Introduced by Representative Keenan of St. Albans City and others
This bill proposes to conform Vermont's health insurance laws to the requirements of a newly enacted federal law, the Health Insurance Portability and Accountability Act of 1996.

H.359 Introduced by Representative Vinton of Colchester and others
This bill proposes to provide for certification of athletic trainers.

H.377 Introduced by Representative Corren of Burlington and others
This bill proposes to direct the departments of banking, insurance, securities, and health care administration and liquor control to study the feasibility of creating a state wholesale drug outlet.

H.390 Introduced by Representative Crawford of Burke and others
This bill proposes to regulate alcohol and drug abuse counselors.

H.395 Introduced by Representative Milkey and others (80)
This bill proposes to require health insurance policies to provide coverage for chiropractic services.

H.396 Introduced by Representative Suchmann of Chester and others
This bill proposes to establish a commission on Alzheimer's disease and related disorders.

H.412 Introduced by Representative Poirier of Barre City and others
This bill proposes to expand the Vermont Health Access Plan with proceeds from Powerball.

H.413 Introduced by Representative Seibert of Norwich and others
This bill proposes to require health insurers to provide coverage for off-labeled cancer treatment drugs.

H.428 Introduced by Representative Howrigan of Fairfield
This bill proposes to license clinical laboratories operating in Vermont and clinical laboratory personnel.

H.435 Introduced by Representatives Mazur of South Burlington and Keenan of St. Albans City
This bill proposes to reduce the cost of workers' compensation premiums for Vermont businesses by authorizing performance-based insurance plans in the residual market, by prohibiting arbitrary discount limitations, and by clarifying the definition of compensable injuries.

H.442 Introduced by Representative Alfano of Calais
This bill proposes to require health insurance companies to provide enrolled individuals access to all health care providers, so long as the treatment is within the provider's scope of practice.

H.450 Introduced by Representative Keenan of St. Albans City
This bill proposes to permit the formation of noncapitalized insurance companies pursuant to a plan of merger or consolidation, to amend the laws regulating nonprofit hospital and medical service corporations, and to permit the organization of a health maintenance organization as a limited liability company.

H.467 Introduced by Representative Paquin of Fairfax and others
This bill proposes to require businesses that make long-term rentals of durable medical equipment to offer consumers an option to purchase such equipment.

H.468 Introduced by Representatives Holmes of Bethel and Dwyer of Thetford
This bill proposes to repeal the community rating provisions of Vermont's health insurance laws, and to establish a high risk health insurance plan.

H.515 Introduced by Representative Kurt of Colchester and others
This bill proposes to reconcile the standards for investments by nonprofit medical service corporations with the standards applicable to any insurance company.

H.517 Introduced by Representative Sweetser of Essex
This bill proposes to require health insurers and Medicaid to provide coverage for HIV testing during pregnancy, and to provide state reimbursement for HIV testing during pregnancy for women who are not insured or Medicaid eligible.

Senate

S.3 Introduced by Senator Illuzzi of Essex-Orleans County
This bill proposes to direct the Medical Practice Board to compile profiles of each licensee and to make that

information available to the public.

S.10 Introduced by Senator Illuzzi of Essex-Orleans County
This bill proposes to authorize pharmacists to order and dispense prescription drugs that are included on a formulary which has been adopted jointly by the boards of pharmacy, medical practice, and osteopathic physicians and surgeons.

S.22 Introduced by Senator Illuzzi of Essex-Orleans County
This bill proposes to authorize a patient to direct his or her health insurer to not reimburse a patient's health care provider.

S.34 Introduced by Senator Chard of Windham County
This bill proposes to expand the scope of persons who are required to report diseases to the department of health.

S.49 Introduced by Senator Sears of Bennington County and others
This bill proposes to provide incentives for insurance companies to pay claims in a timely manner.

S.71 Introduced by Senator Rivers of Windsor County and others
This bill proposes to create the Vermont consumer health care association to represent the interests of consumers who are members of the association.

S.75 Introduced by Senator Rivers and Senator Illuzzi
This bill proposes to permit an individual injured as a result of a violation of the insurance trade practices act to file a civil action seeking judicial remedies for the violation.

S.78 Introduced by Senator Illuzzi of Essex-Orleans County
This bill proposes to consolidate and strengthen the privacy and confidentiality safeguards for individually identifiable health care information.

S.84 Introduced by Senator Shumlin of Windham County and others
This bill proposes to establish standards and procedures for the coverage of medically necessary treatment.

S.86 Introduced by Senator Barry of Chittenden County et al
This bill proposes to require health insurers to provide coverage for prescribed self-management training, equipment, and supplies for the treatment of diabetes.

S.105 Introduced by Senator Backus of Chittenden County and others
This bill proposes to require health insurance plans to cover treatment of craniofacial disorders.

S.159 Introduced by Senator Spaulding of Washington County and Senator Backus of Chittenden County
This bill proposes that whenever the state pays a private contractor at least $100,000 annually to provide personal services, the contractor shall be required to provide its employees with health insurance benefits equivalent to those provided to state employees.

S.168 Introduced by Senator Riehle of Chittenden County and others
This bill proposes to change the administrative structure of the board of medical practice and to attach the board to the division of health care administration within BISHCA for purposes of administrative oversight.

S.172 Introduced by Senator Ready of Addison County
This bill proposes to require health care plans to provide coverage for treatment by any health care provider, provided the treatment is within the provider's scope of practice.

S.178 Introduced by Senator Maynard of Rutland County
This bill proposes to expand the scope of the practice of podiatry to include diagnosis and treatment of ailments of the lower leg, amputation of toes, and use of anesthetics for these purposes.

	Managed Care Regulation				Mandated Benefits			Access	
	Patient Disclosure- "Gag Clause"	Mandatory POS	Direct Access	PSO Over-Sight	Mastectomy Stay	ER Services	Mental Health Parity	HIPAA Implemen-tation	Child Health
Alabama	x	x	x			x		x	
Alaska	x	x	x			x	x		x
Arizona	x	x	x		x		x	x	
Arkansas	x		x		x		x	x	x
California			x		x	x	x	x	x
Colorado							x	x	x
Connecticut	x	x	x	x	x	x	x	x	x
Delaware									
Florida	x		x	x	x		x	x	x
Georgia	x		x		x	x	x	x	
Hawaii	x	x	x			x	x	x	x
Idaho	x	x	x			x		x	
Illinois	x	x	x		x	x	x	x	x
Indiana	x	x					x	x	x
Iowa	x	x			x		x	x	x
Kansas	x		x			x	x	x	
Kentucky	Not In Session								
Louisiana	x				x		x	x	x
Maine			x		x			x	x
Maryland		x	x	x	x	x		x	x
Massachusetts	x	x			x	x	x		x
Michigan	x		x						
Minnesota	x		x		x	x		x	
Mississippi	x		x		x	x		x	x
Missouri	x	x	x	x	x	x	x	x	x
Montana	x	x	x	x	x		x	x	x
Nebraska	x		x				x	x	x
Nevada	x		x			x			
New Hampshire		x	x			x		x	x
New Jersey	x	x	x	x	x	x			x
New Mexico	x	x		x	x		x	x	x
New York			x		x		x	x	x
North Carolina	x				x	x	x	x	
North Dakota	x							x	
Ohio	x				x	x		x	x
Oklahoma	x	x	x		x	x	x	x	x
Oregon	x		x		x		x		x
Pennsylvania	x	x	x	x	x	x	x	x	x
Rhode Island	x		x	x	x	x		x	x
South Carolina	x	x	x		x	x		x	x
South Dakota							x	x	x
Tennessee		x	x		x	x		x	
Texas	x	x	x		x	x	x	x	x
Utah	x		x				x	x	
Vermont		x	x				x	x	x
Virginia			x		x			x	x
Washington				x	x	x	x	x	x
West Virginia	x	x	x			x		x	
Wisconsin					x				x
Wyoming	x							x	
Totals	36	23	35	10	31	27	29	41	34

SELECTED FINDINGS
VERMONT BUSINESS ROUNDTABLE HEALTH CARE TASK FORCE
SURVEY OF MEMBERSHIP
JULY 1997

- In the summer of 1997, the Vermont Business Roundtable surveyed its members about the cost and impact of health care regulation in Vermont. Seventy-five CEO's responded to the survey. A thumb-nail sketch of the respondents reveals that most manage companies based only in Vermont (61%). On average, the companies in the sample employ 3,461 workers (the median is 177 workers). Multi-state companies are much larger than the Vermont-only based companies. The former average 8,332 employees versus 548 employees in Vermont-only based companies. (Vermont employment levels of the multi-state companies are quite close to the levels in Vermont-only based firms). Eleven percent are unionized. The plans of the companies surveyed offer a full range of health benefits including payment for such standard items as hospitalization, routine medical care, prescription drugs, and dental care. Less than one-half of the companies offer vision benefits or health counseling (diet, exercise, alcohol, drugs...). A slight majority of the companies are now self-insured, while 30% rely on HMO's for health care.

- Companies in Vermont are quite troubled about the high cost of doing business in the state. Just over two out of three believe it is more expensive to conduct business in Vermont than elsewhere in New England. Only 4% believe the cost to be lower. Companies that also operate outside of Vermont feel that the cost of doing business in Vermont is even higher than those which only operate within the state.

- Although respondents are concerned about the relatively high cost of doing business in the state, most feel that health care costs are either similar or lower in Vermont than elsewhere. Only 20% feel costs are higher in Vermont than in other New England states. Answers did not vary significantly between companies that are Vermont or multi-state based. To say that many respondents feel that health care costs are either lower or no higher in Vermont than elsewhere does not mean that they are not worried about the overall cost levels. Companies have been changing insurance carriers, self-insuring, and limiting benefits to constrain rising health care costs.

- Two out of three companies believe that fringe benefit costs are either a significant or very significant cost of doing business. Companies spend approximately 23% of their payroll costs on fringe benefits, 36% of which is accounted for by health insurance benefits.

- Health care costs have increased by 23% over the last 5 years for the average respondent. This rate is slightly higher than the general rate of inflation but much lower than the spiraling costs of the 1980's. Costs have increased by 20% over the last 5 years for those who are currently self-insured, 24% for those with commercial companies, 29% for those with Blue Cross, and 32% for those with HMO's (these figures do not take into account the possibility

that firms changed insurance policies during this time period.). One-third of the companies have experienced cost increases of under 10% during this 5-year period. In response to rising health care costs, nearly one-half of the respondents have either added or increased co-payments, while one-third have increased deductibles. One firm dropped coverage. Nearly one in five have cut costs by self-insuring. Smaller firms in the sample were more likely to limit or drop coverage or increase deductibles in the face of rising costs.

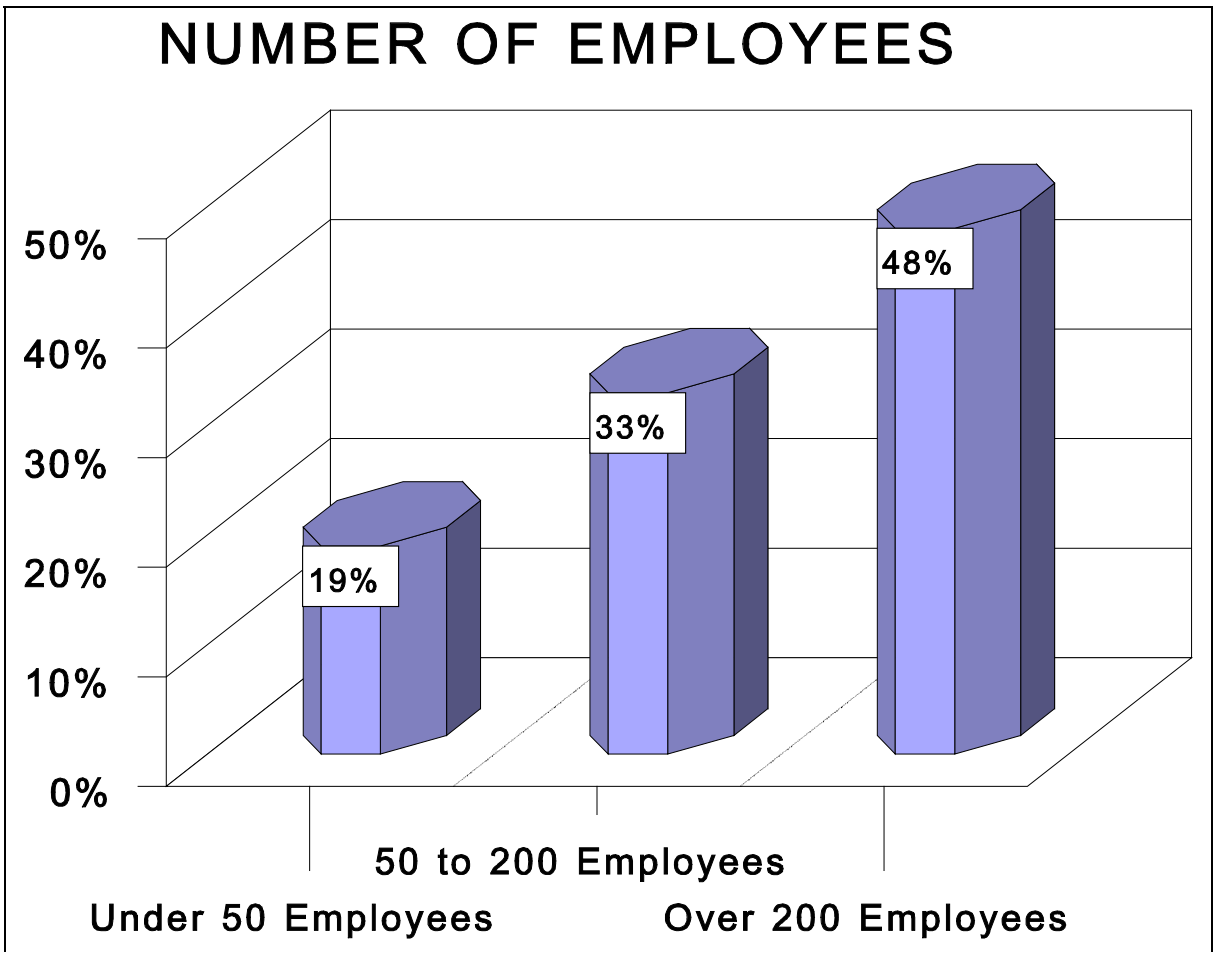
- Eighty-one percent of the health plans offered by the companies in the sample provide some form of preventative health benefits. The most common is payment for routine screenings for things like pap smears, blood pressure, and mammograms (75%), routine office visits (68%), and immunizations for well- babies (67%). Counseling for problems like diet, exercise, and alcohol are far less likely to be covered (42%). Only 1 respondent felt that preventative programs should not be included in standard insurance programs. Not surprisingly, a very high percent, 91%, felt that these types of program will save money in the long run. Preventative health benefits are more likely to be found in the plans offered by larger companies. For example, health counseling (diet, exercise, alcohol or tobacco use...) is available in only 9% of the plans in small companies (under 50 employees), while it is provided in the plans of 50% of medium firms (50 to 200 employees) and 57% of large firms.

- In designing health care packages, the number one consideration of respondents is “quality” followed by “cost.” Issues of “choice” and “access” appear less important.

- The cost of health insurance varied substantially within the sample. Cost per employee for health insurance, which averaged $226 per month, ranged from a low cost per employee of $48 to a high of $638. Cost per employee varied by the type of policy and the range of services offered. Companies with HMO plans had the lowest rates at $192 per month per employee followed by commercial insurers at $208. Companies that self-insure require employees to pay $247 per month per employee for health insurance.

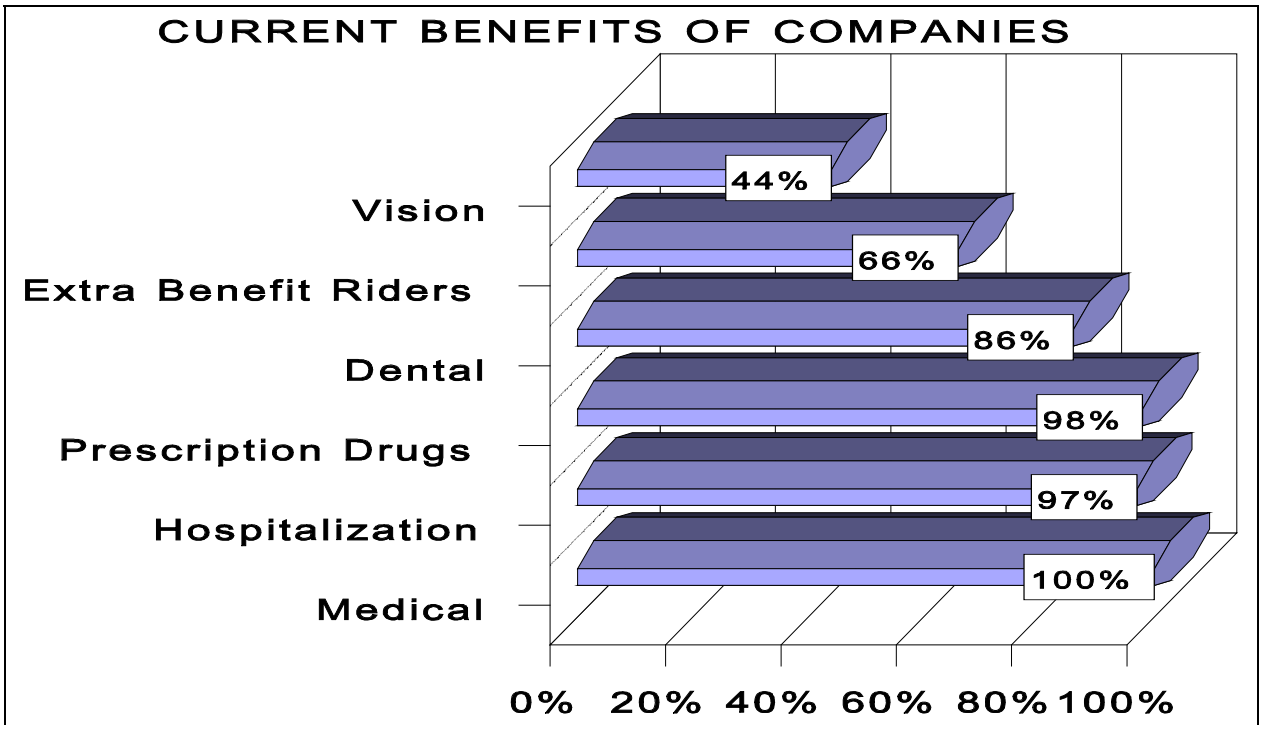
- While most companies did not calculate, on their own, the cost of proposed state mandated benefit changes, they would, overwhelmingly, like to see the state conduct cost-benefit analysis of mandated changes in fringe benefits. Some respondents believed that cost-benefit analysis should be conducted for all new proposals. At the other end of the spectrum where respondents who felt that cost-benefit analysis should be conducted only if the likely impact surpassed $10,000,000.

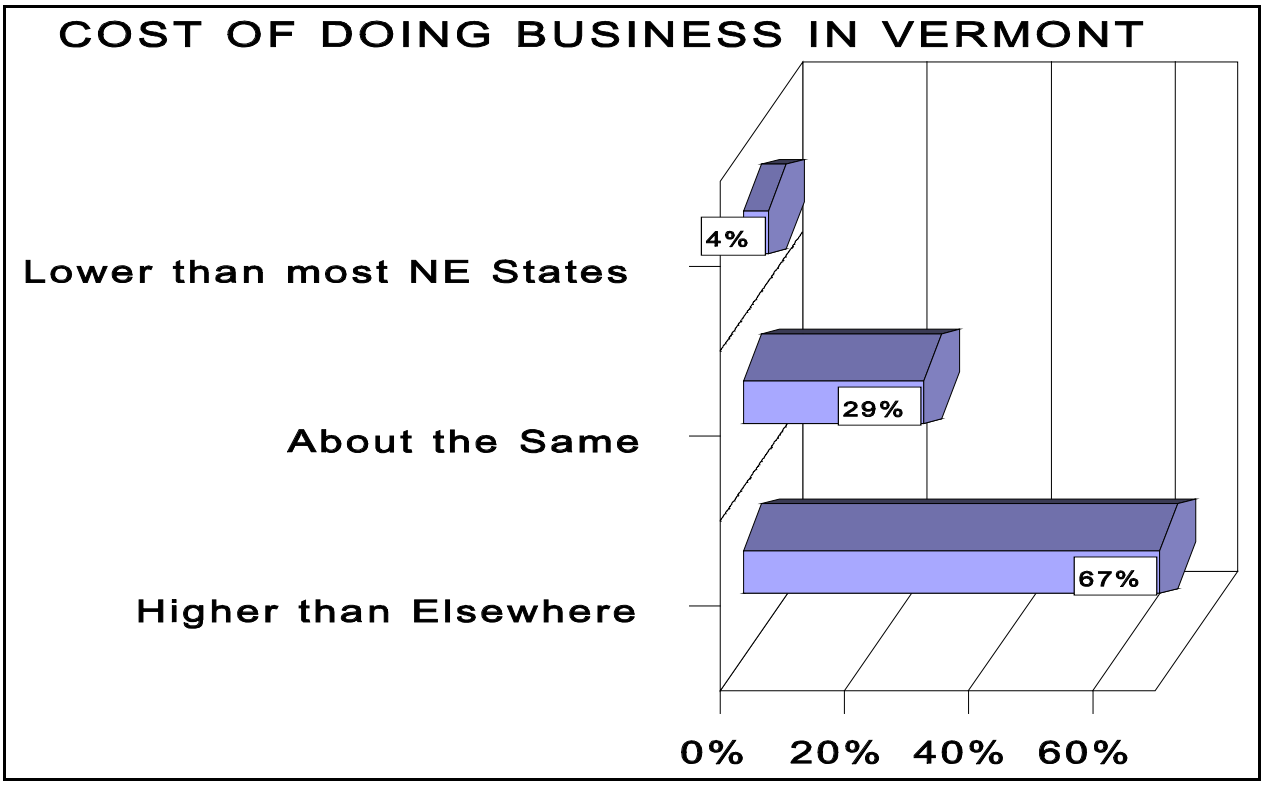
- A majority of the multi-state and Vermont-only based companies agree that the amount of fringe benefit regulation in the state is greater than elsewhere. Only 3% feel that it is less than elsewhere. According to the respondents, higher fringe benefit costs would decrease the likelihood of expanding in Vermont (69% agreed). Fewer would either move out of Vermont (20% might) or leave their business (17%) due to higher mandated fringe benefit costs.

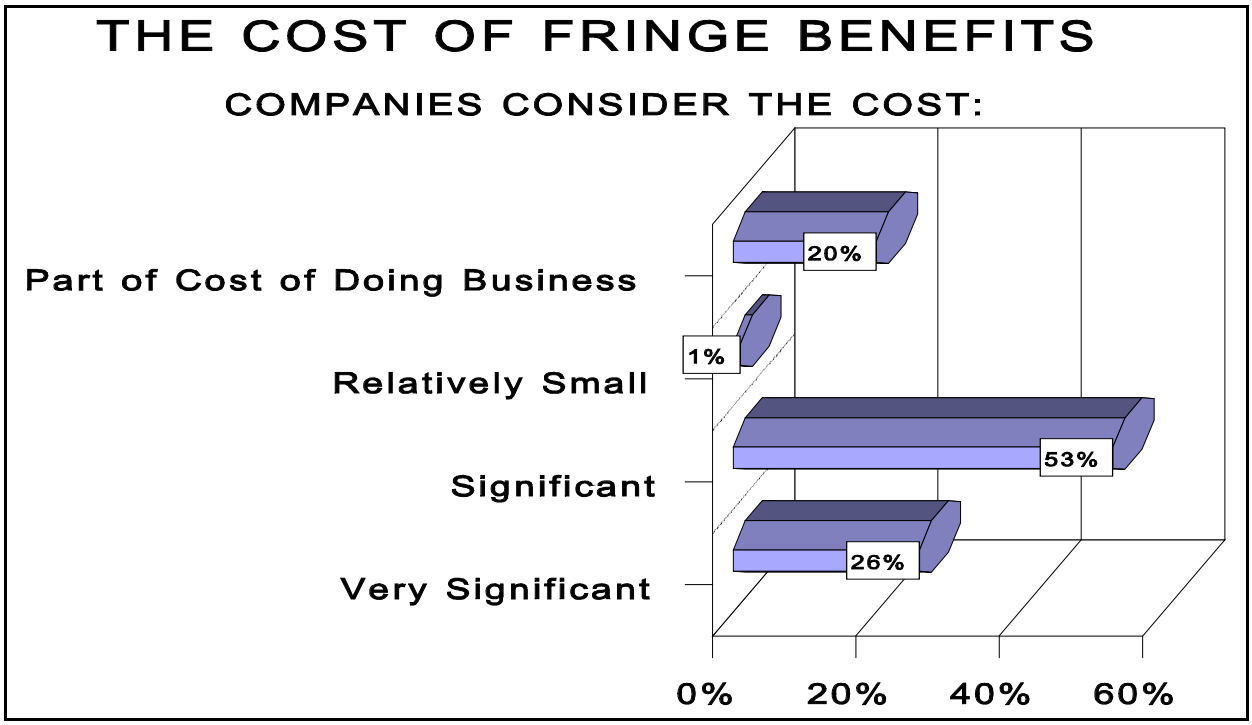


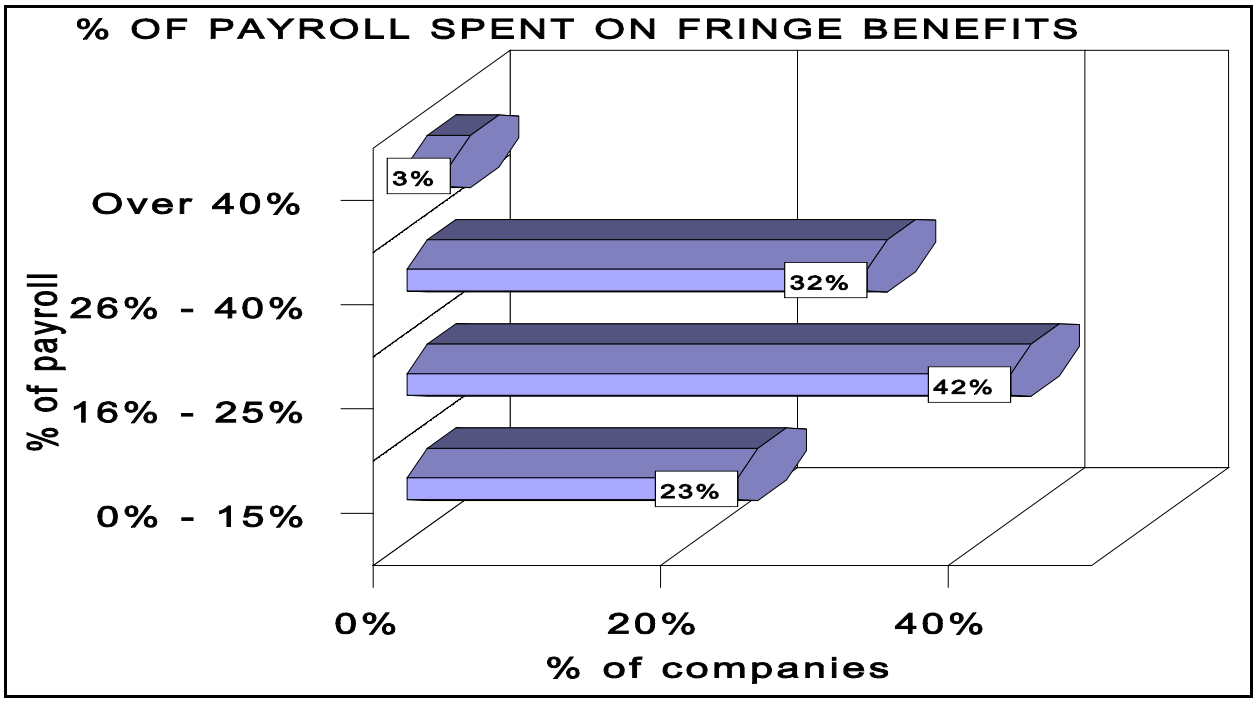
EMPLOYMENT LEVELS
(Number of Workers)

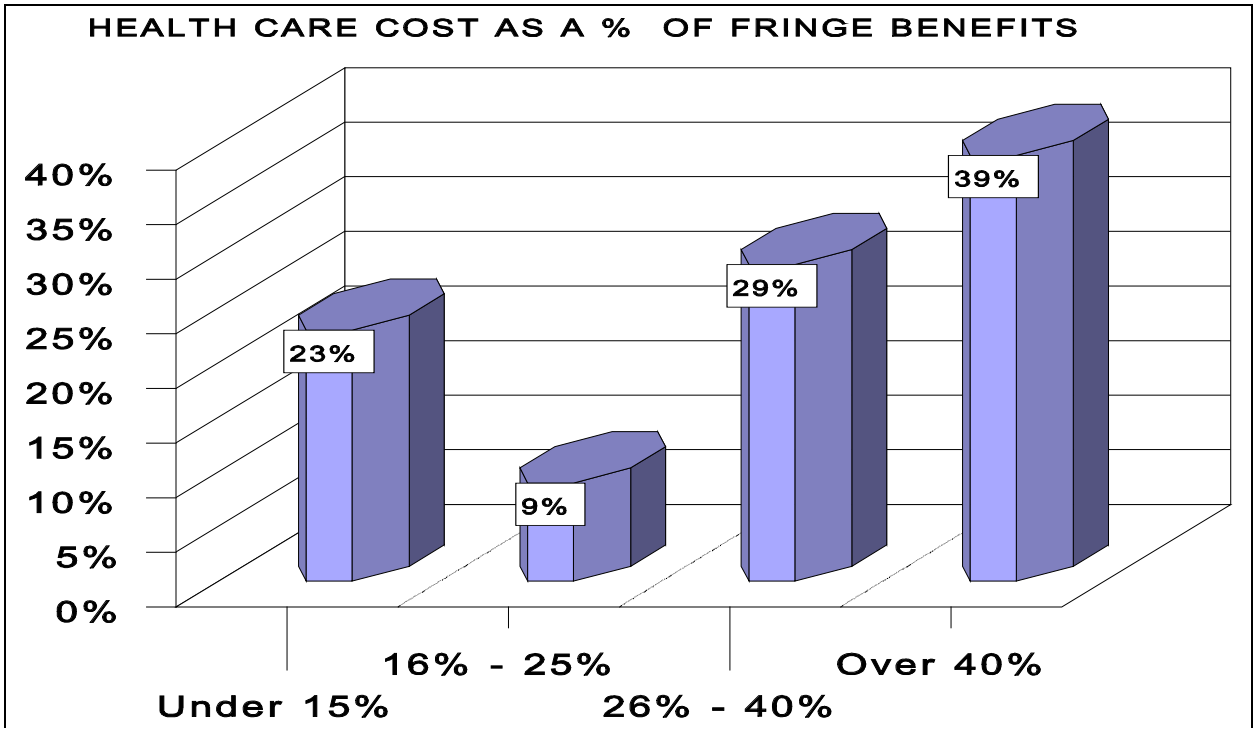
	Vermont-Only Based Company	**Multi-State Company**
Total Employment	548	8,332
Within Vermont	546	588

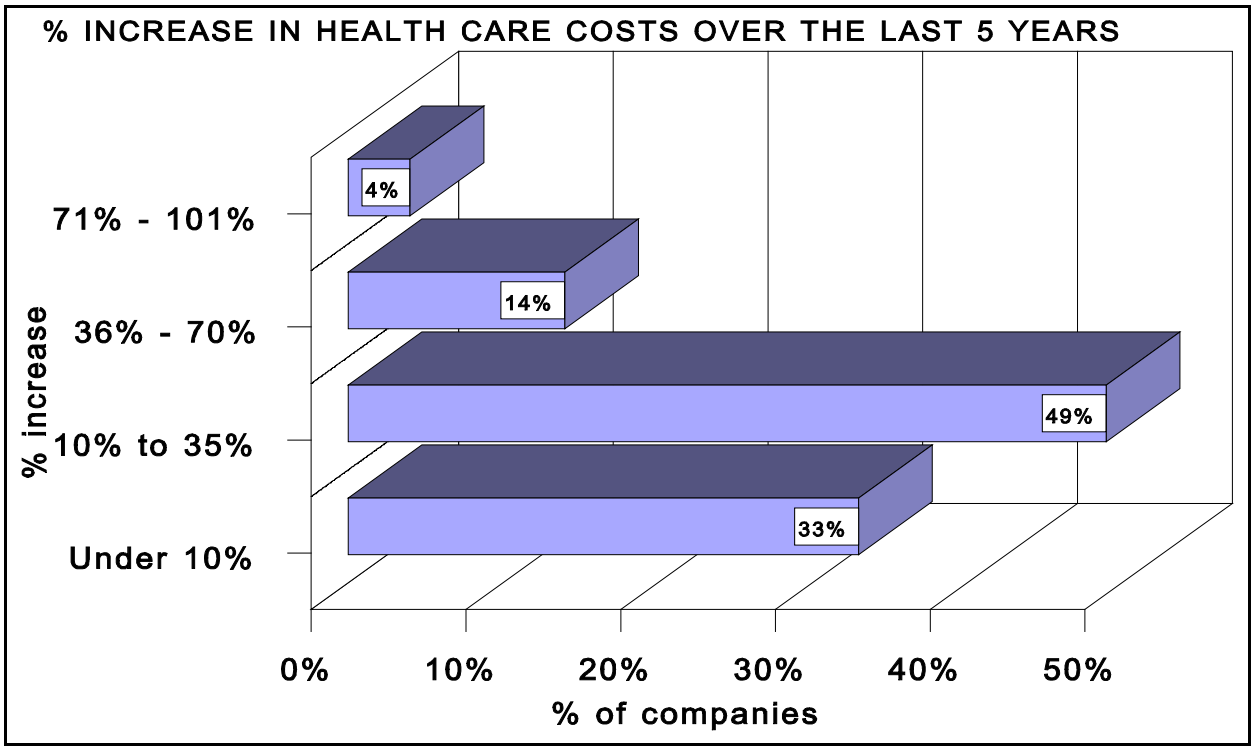

CURRENT BENEFITS OF COMPANIES
Vision
Extra Benefit Riders
Dental
Prescription Drugs
Hospitalization
Medical
44%
66%
86%
98%
97%
100%
0%
20%
40%
60%
80%
100%

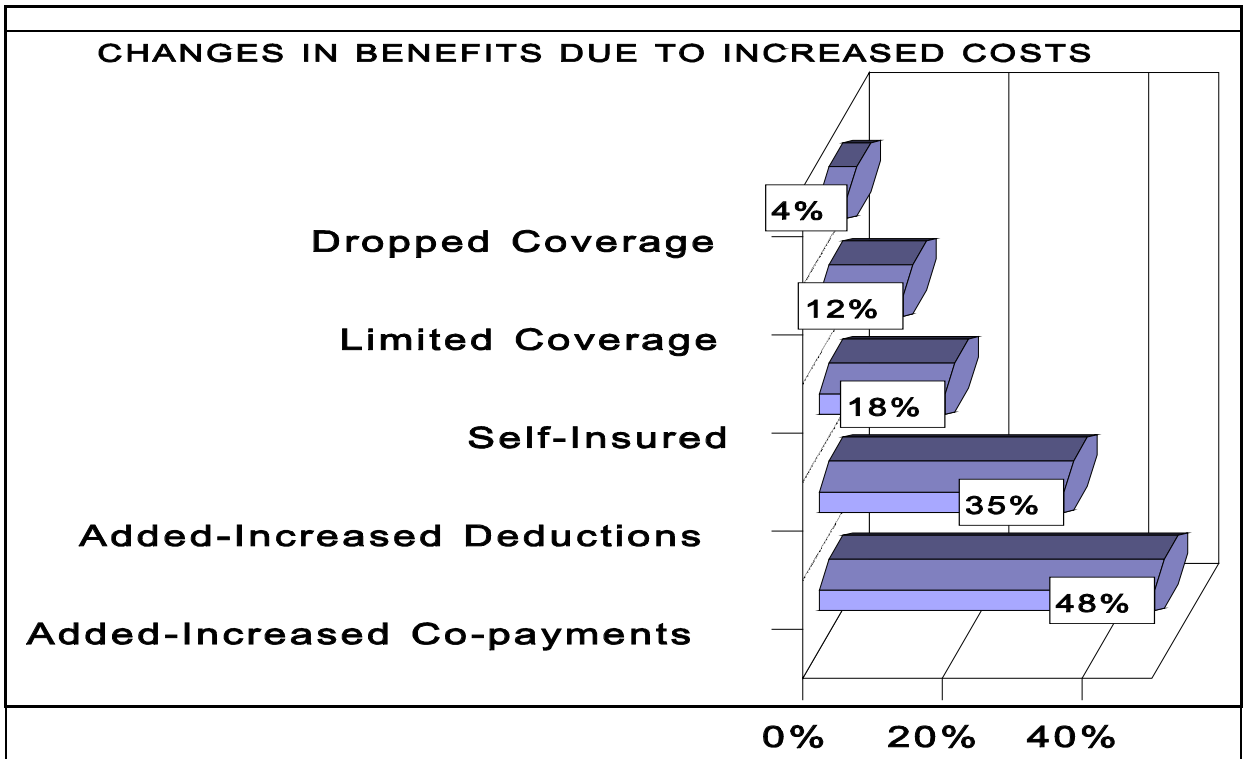

COST OF DOING BUSINESS IN VERMONT
Lower than most NE States
About the Same
Higher than Elsewhere
4%
29%
67%
0%
20%
40%
60%

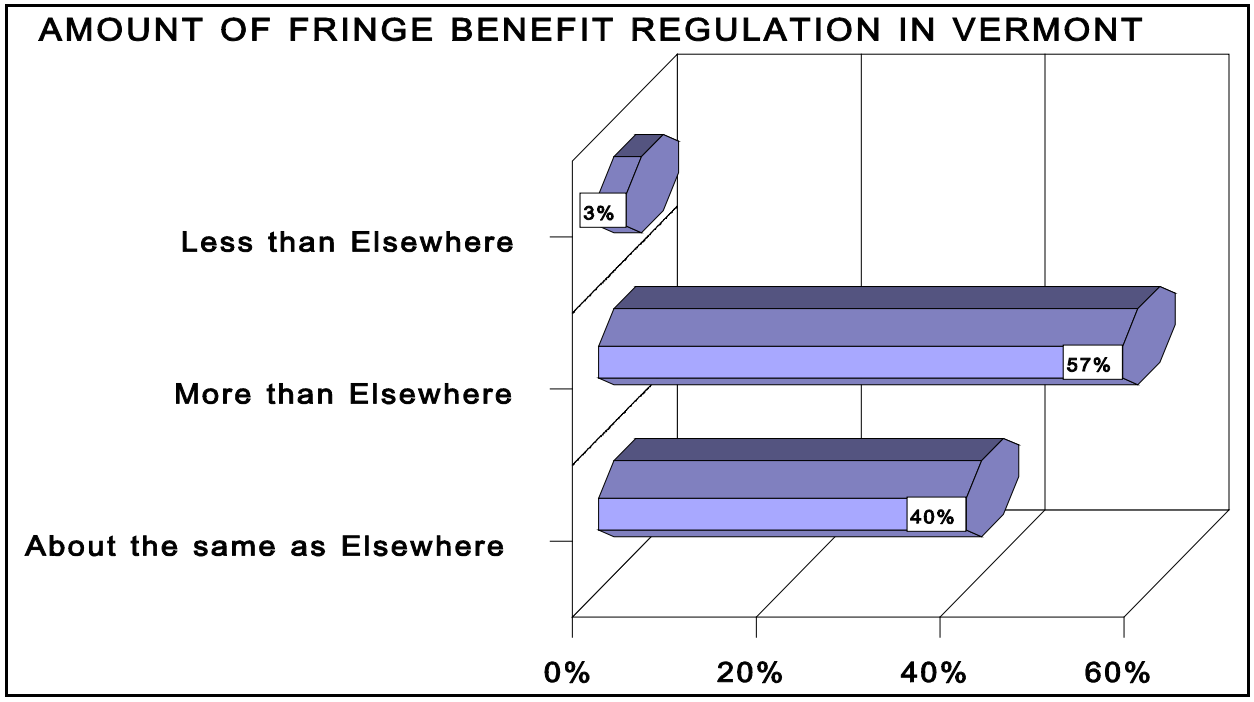

THE COST OF FRINGE BENEFITS
COMPANIES CONSIDER THE COST:
Part of Cost of Doing Business
Relatively Small
Significant
Very Significant
20%
1%
53%
26%
0%
20%
40%
60%

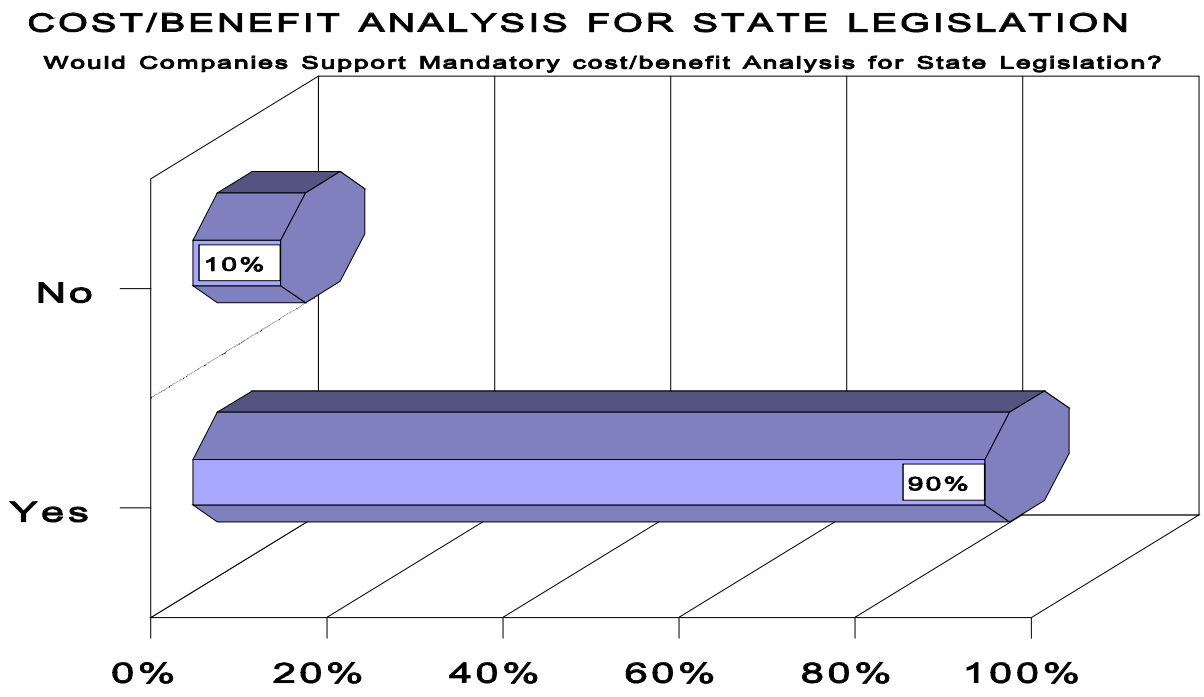

% OF PAYROLL SPENT ON FRINGE BENEFITS
% of payroll
Over 40%
26% - 40%
16% - 25%
0% - 15%
3%
32%
42%
23%
0%
20%
40%
% of companies


HEALTH CARE COST AS A % OF FRINGE BENEFITS
40%
35%
30%
25%
20%
15%
10%
5%
0%
23%
9%
29%
39%
Under 15%
16% - 25%
26% - 40%
Over 40%


% INCREASE IN HEALTH CARE COSTS OVER THE LAST 5 YEARS
% increase
71% - 101%
36% - 70%
10% to 35%
Under 10%
4%
14%
49%
33%
0%
10%
20%
30%
40%
50%
% of companies


CHANGES IN BENEFITS DUE TO INCREASED COSTS
Dropped Coverage
Limited Coverage
Self-Insured
Added-Increased Deductions
Added-Increased Co-payments
4%
12%
18%
35%
48%
0%
20%
40%


AMOUNT OF FRINGE BENEFIT REGULATION IN VERMONT
Less than Elsewhere
More than Elsewhere
About the same as Elsewhere
3%
57%
40%
0%
20%
40%
60%


COST/BENEFIT ANALYSIS FOR STATE LEGISLATION
Would Companies Support Mandatory cost/benefit Analysis for State Legislation?
No
Yes
10%
90%
0%
20%
40%
60%
80%
100%

Appendix 4
MANDATED BENEFITS REVIEW ACT

Summary

The purpose of this Act is to initiate a review of all current and proposed state-mandated benefits. Mandated health insurance benefit laws require that health insurance contracts cover specific diseases and disabilities and provide for specific health care services. With few exceptions, mandated benefits raise the cost of conventional health insurance. In fact, it is estimated that as many as one out of every four people who lack health insurance have been priced out of the market by costly mandates. [4] And one insurance company in Massachusetts estimates that mandated benefits add nearly $55 per month to the cost of a policy.[5]

ALEC's bill would create an independent committee to review all current state-mandated benefits. The committee would be charged with reviewing the cost effectiveness, the medical efficacy, and the social need for each mandated benefit. All existing mandated benefits and mandated health insurance coverage would expire within one year after the effective date of the Act unless specifically reauthorized by the legislature on the basis of the committee's findings. All future, proposed mandated benefits would need a financial impact statement and a recommendation of need from the committee.

Model Legislation

{Title, enacting clause, etc.}

Section 1. This Act may be cited as the **Mandated Benefits Review Act.**

Section 2. {**Statement of Purpose.**}

The purpose of this Act is to provide for independent review of mandated benefits. This Act requires that all existing mandated health benefits, proposals or an amendment to a proposal for mandated benefits, mandated health insurance coverage, and mandated offerings of health benefits be accompanied by independently certified documentation with regard to the proposals' social impact, medical efficacy, and financial impact.

Section 3. {**Mandated Health Benefits Review Panel**.}

(A) {Documentation.} Proposals or amendments to a proposal for mandated health benefits or mandated health insurance coverage shall be accompanied by adequate independently certified documentation defining the proposals' social impact, medical efficacy, and financial impact.

Mandated benefits shall include:

(1) any mandated coverage for specific services, treatments or practices;

(2) any mandated direct reimbursement to specific health care practitioners;

(3) any mandated offering for specific services, treatments or practices; and

(4) any mandated reimbursement amount to specific health care practitioners.

(B) {Report.} Every person or organization that promotes or seeks sponsorship of a legislative proposal or an amendment to a proposal that does or would mandate a health coverage or offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies shall submit a report to the legislative committee having jurisdiction. The committee shall refer the proposal or any amendment to a proposal for review to the mandated benefits review panel created by this Act.

(C) {Panel.} The panel shall consist of three senior researchers, two being experts in health research or biostatistics chosen from universities within the state and the third a senior research associate, each appointed by the "Secretary of Health."

(D) {Panel's report.} The panel will review the documentation submitted with the proposed legislation and will issue

a report within 30 days as to:

(1) whether the information is complete;

(2) whether the research cited meets professional standards;

(3) whether all relevant research has been brought to light;

(4) whether the conclusions and interpretations drawn from the evidence are consistent with the data presented. If the panel reaches a favorable conclusion on all points, the documentation will be certified accordingly. If the panel finds the documentation deficient, the panel will identify the deficiencies. The panel shall judge the completeness of the information provided and the validity of the conclusions drawn, based on the facts presented, but shall not comment upon the merits of desirability of the proposal.

(E) {Guidelines.} The panel will apply the following guidelines in determining the adequacy of the information presented:

(1) the panel should consider evidence of social impact, i.e., to what extent is the treatment or service:

(a) needed by the people of this state;

(b) available to the people of this state; and

(c) utilized by the population of this state.

(2) if insurance coverage is not generally in place, the panel should determine to what extent the lack of coverage results in inadequate health care and/or major financial hardship.

(3) the panel should determine the demand for the proposed health care coverage from the public at large and in collective bargaining negotiations.

(4) the panel should determine if all relevant findings bearing on social impact have been presented.

(5) the panel should consider evidence of medical efficacy:

(a) if the legislation seeks to mandate coverage of a particular therapy;

(I) the results of at least one professionally acceptable, controlled trial demonstrating the medical consequences of that therapy compared to no therapy and to alternative therapies;

(ii) the results of any other relevant research.

(b) if the legislation seeks to mandate coverage of an additional class of practitioners:

(I) the results of at least one professionally acceptable, controlled trial demonstrating the medical results achieved by the additional class of practitioners relative to those already covered;

(ii) the results of any relevant research.

(6) the panel should review the evidence of financial impact:

(a) the extent to which the coverage will increase of decrease the cost of treatment or service;

(b) the extent to which similar mandates have affected charges, costs, and payments experienced in other states with such mandates;

(c) the extent to which the coverage will increase the appropriate use of treatment or service;

(d) the extent to which the mandated treatment or service will be a substitute for more expensive or less expensive treatment or service;

(e) the extent to which the coverage will increase or decrease the administrative expenses of insurance companies in the premium and administrative expenses of policy holders;

(f) the extent to which existing mandates meet the requirements of the Act;

(g) the financial impact of this coverage on small employers, medium-sized employers and large employers;

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

Section 4. {Review of Existing Mandated Benefits.}

(A) In addition to the duties prescribed by this Act, the panel shall undertake a separate and complete review of all existing state mandated benefits, mandated health insurance coverage, and mandated offerings of health benefits in the same manner as prescribed in Sections 2 and 3 of this Act. The panel shall report its findings of existing state-mandated benefits, mandated health insurance coverage, and mandated offerings of health benefits to the legislative committee heaving jurisdiction no later than (insert date).

(b) All existing mandated benefits, mandated health insurance coverage, and mandated offerings of health benefits shall expire within one year after the effective date of this Act unless specifically reauthorized by the legislature on the basis of the review required under Subsection (A) of this Section.

Section 5. {Severability clause.}

Section 6. {Repealer clause.}

Section 7. {Effective date.}

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1. Summary of health related bills introduced during the 1997 Vermont legislative session. Prepared by Leigh Tofferi, Blue Cross Blue Shield of Vermont.

2. Summary of health care reform legislation as of 5/1/97. Prepared by the Blue Cross Blue Shield Association staff in Washington, D.C.

4. A 1988 econometric study by the National Center for Policy Analysis concluded that 14% to 25% of the uninsured population were unable to buy insurance due to the cost of mandates. A 1992 study reported in the Journal of Public Economics (authors Gabel and Jensen) estimated that mandated benefits prevented one in five small firms that do not offer health insurance from doing so. A 1992 study by Blue Cross and Blue Shield companies in 13 states found that monthly group premium rates (or claims payment costs) rose between 5% and 21% per state that year as a result of the aggregate cost of benefit mandates. A NFIB (National Federation of Independent Businesses) Education Foundation study found that existing mandates increase premiums up to 30%, according to a letter from Dan Danner, NFIB Vice President, to Newt Gingrich dated 2/4/97. For related research, see EBRI (Employee Benefit Research Institute) brief titled, "Issues in Mental Health Benefits," February 1997.

5. See testimony of Jeanne Keller, Vermont Employers Health Alliance, on H-57, 5/9/97. Also see "An Actuarial Analysis of Comprehensive Mental Health and Substance Abuse Parity," January 1997, Ronald E. Bachman, FSA, Coopers & Lybrand.

6. Testimony of the Blue Cross Blue Shield Association, State Mandates on Health Benefits, Mary Nell Lehnhard, Vice President, before the U.S. Subcommittee on Health, House Ways and Means Committee, July 29, 1991.

7. Selected Findings, Vermont Business Roundtable Health Care Task Force Survey of Membership, July 1997.

8. Gabel and Jensen, bibliographic notation 4 (above). For related research, see "Employment Based Health Insurance: Costs Increase and Coverage Decreases," GAO/HEHS-97-35., by U.S. Government General Accounting Office, phone 202-512-6000.

9. See bibliographic notation 4 (above).

10. National Council on Medical Management, policy paper on Outpatient Mastectomies, Blue Cross Blue Shield Association, Chicago. Summarizes studies by Clark & Kent, Department of Surgery, Methodist Medical Center, Birmingham, Alabama; Kambouris, Department of Surgery, Henry Ford Hospital, Detroit; Goodman and Mendez, Plantation, Florida. All from Archives of Surgery.

11. Issues Review, "States Turning to Evaluation Laws to Curb Mandated Benefits," April 1997. Published by Blue Cross Blue Shield Association, Washington, D.C.

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